

TO HOSPITAL: FENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called in.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8 / 20 995 REG. NO.											2b HOUR 3:59 P.M.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST John	MIDDLE A.	LAST Polutchko	2a. DATE OF DEATH MONTH July DAY 1 YEAR 1987			2b. HOUR 3:59 P.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH Sept. DAY 1 YEAR 1908			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN. 0		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION Plant Manager			12b. KIND OF BUSINESS OR INDUSTRY Textile						
13a. STATE Pennsylvania		13b. COUNTY Monroe		13c. CITY OR TOWN Stroudsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 216 Huston Avenue/18360 99999					
14. FATHER'S NAME FIRST John		MIDDLE A.		LAST Palocko	15. MOTHER'S MAIDEN NAME FIRST Katarina		MIDDLE LAST Rigelski						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) 166-05-5024		17. INFORMANT John A. Polutchko, Jr. Arlington, VA 22207		ADDRESS 3130 N. Inglewood St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYELOFIBROSIS</u> > (c) <u>HYPOPROLIFERATIVE SYNDROME</u> 15 YEARS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 21a. DATE OF OPERATION													
21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) IF EITHER, NOTIFY MEDICAL EXAMINER)		21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from 7/7/87 to 7/7/87, that (2) we last saw the deceased alive on 7/7/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) did not view the body after death.		22b. SIGNATURE Barry Raskin, MD.		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 7/8/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY RASKIN, MD.		22e. ADDRESS 8218 WISCONSIN AVE P-9 BETHESDA, MD											
23a. BURIAL, CREMATION, REMOVAL (Burial)		23b. DATE July 14, 1987		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		23d. LOCATION CITY OR TOWN Pringle, Pennsylvania		23e. COUNTY Pennsylvania		23f. STATE			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814		25a. DATE REC'D. BY REGISTRAR JUL 13 1987		25b. REGISTRAR'S SIGNATURE									

HMH 16-60M 7/84
(VRA 5, 4)

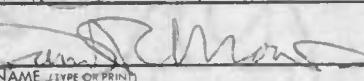
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been signed by the attending physician, page 3
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, pages 1 and 2 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 20996			
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Martha Elizabeth Schaaff Porter									7-20-87				11 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Month Day Year April 30, 1896			91 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.		
Washington, D.C.		United States					Montgomery						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg		403-Russell Avenue		13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		at home		
14. FATHER'S NAME		FIRST T. MIDDLE		LAST Schaaff			15. MOTHER'S MAIDEN NAME		FIRST Lillian MIDDLE May LAST Arnold				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		Weston, CT 06883				
No		114-24-4565		Walter J. Porter, Jr. (Son) #31-Codfish Lane,									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4 months													
DUE TO, OR AS A CONSEQUENCE OF (b) Mitral & Aortic Valvular disease 20 years													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c) —													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Azotemia, Osteoporosis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (this hospital) attended the deceased from <u>Aug 16</u> , 19 <u>77</u> , to <u>July 20</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>June 29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.													
22b. SIGNATURE 		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 7-20-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr.		22e. ADDRESS 207 Bratton Ave Gaithersburg Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 21, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory		23d. LOCATION CITY OR TOWN Washington, District of Columbia		STATE					
24. FUNERAL DIRECTOR NAME J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC20002		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 28 1987		25b. REGISTRAR'S SIGNATURE Julia Dawson-Reader							

021020 JUL 29 1980



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove original paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event, or other traumatic event, the medical examiner should be notified.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

060502 JUL 23 87

87 REG. NO. 20491

1. BASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR
Robert Thorpe Powell.						July 20, 1987	12:30 A.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	IF UNDER 24 HRS		
MALE	WHITE	MONTH DAY YEAR MARCH 26, 1907	MONTHS	YEARS	MONTHS	YEARS	MONTHS	YEARS	MIN.	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. BALTIMORE CITY OR COUNTY OF DEATH							
NORTH CAROLINA	U. S. A.	NEVER MARRIED DIVORCED	MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
TAKOMA PARK	HERITAGE HEALTH CARE				SERVICE STATION MAR					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS/ ZIP CODE	20903 843 NORTHAMPTON DRIVE					
MD	MONT.	SILVER SPRING								
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
CHARLES		GREGORY	Powell	BETTIE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT	ADDRESS						
NO	578-12-1371		BARBRA A. BENN	9809 DILSTON RD S S. MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic lung cancer</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (1) this hospital attended the deceased from saw the deceased alive on <u>7/12/1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.	April 19, 1987 to July 19, 1987, that (1) (we) last									
22b. SIGNATURE <u>Charles Benner MD</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS MD 20904 11161 New Hampshire Ave. Silver Spring									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE JULY 24, 1987	23c. NAME OF CEMETERY OR CREMATORIAL GEORGE WASHINGTON CEMETERY	23d. LOCATION ADELPHI							
23e. CEMETERY Takoma Funeral Home	23f. ADDRESS 254 Carroll St. N. W. D. C.	23g. DATE REC'D. BY REGISTRAR E.I.I.I. 22 1987	23h. REGISTRAR'S SIGNATURE Julia Dawson-Randall							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be tied with 2 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner should be notified.

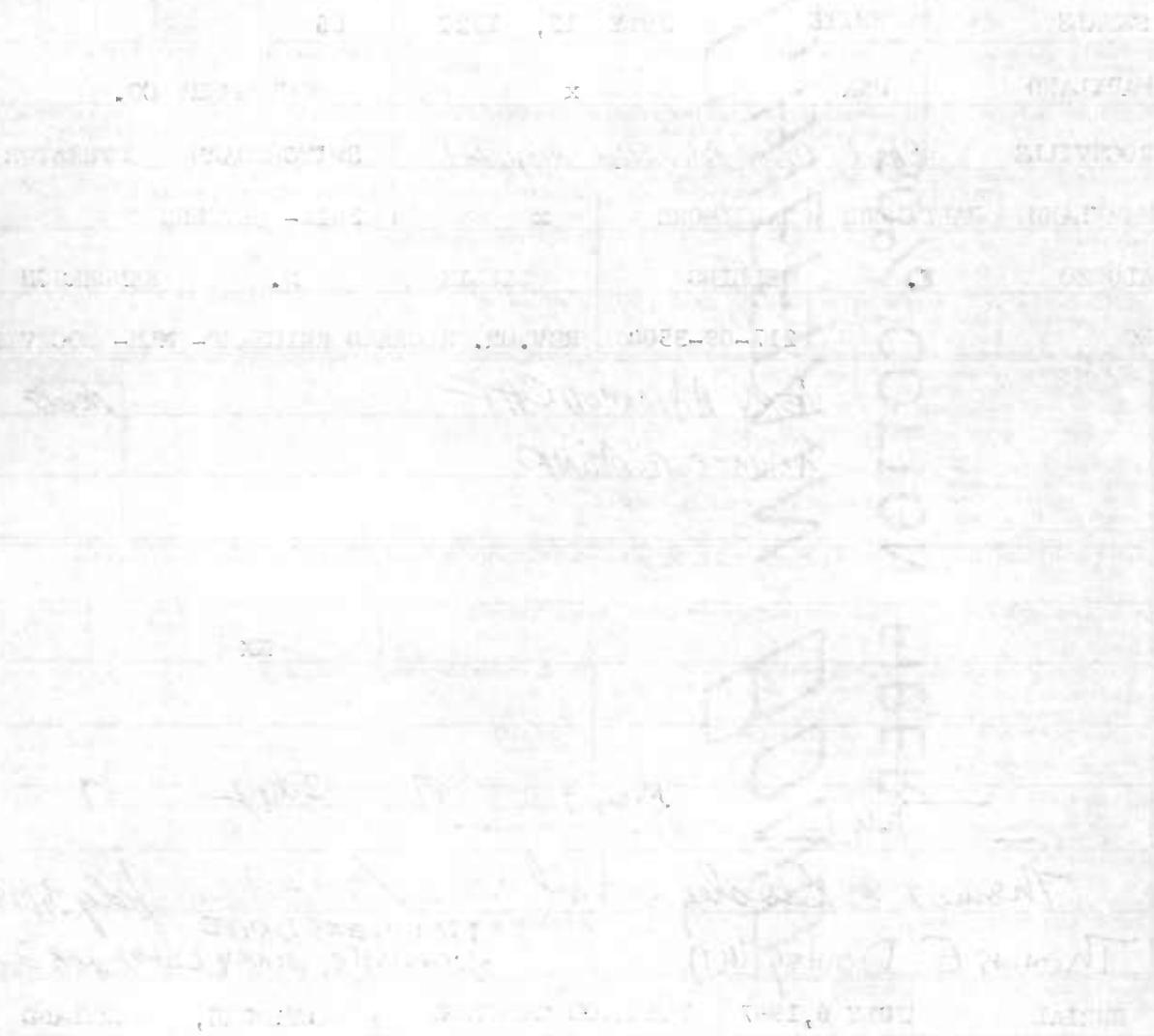
Item 13a Phone CN 7-34 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Alma R Raab						7	2	87	2023PM		
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE			WHITE		JULY 15, 1920	IF UNDER 1 YEAR MONTHS DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND			USA			MONTGOMERY CO. MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
ROCKVILLE			Shady Grove Adventist Hospital		SWITCHBOARD.					OPERATOR	
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS ZIP CODE					
MARYLAND			BALTIMORE	BALTIMORE	3818 BEYONNE	2111 VLIERS DR. 20850					
FATHER'S NAME			MIDDLE	LAST	FIRST	15. MOTHER'S M AIDEN NAME					
ALONZO			F.	WILLING	LILLIE	MIDDLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT	LAST					
NO			217-09-3504		REV. DR. RICHARD REICHARD	HENDERSON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VERY Advanced CHF</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Advanced ASHD</u>											<u>Acute</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>May 3, 1987</u> to <u>July 1, 1987</u> , to <u>July 2, 1987</u> , that (I) <u>we</u> last saw the deceased alive on <u>July 1, 1987</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>did</u> (did not) view the body after death.											
22b. SIGNATURE Thomas E. Dooley			22c. DATE SIGNED July 3, 1987								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooley (M.D.)			22e. ADDRESS 9701 VLIERS DRIVE ROCKVILLE, MARYLAND 20832								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JULY 6, 1987	23c. NAME OF CEMETERY OR CREMATORIAL PARKWOOD CEMETERY		23d. LOCATION CITY OR TOWN BALTIMORE,		COUNTY MARYLAND	STATE		
24. FUNERAL DIRECTOR NAME HYSONG CO., INC. - 1300-N ST., NW WASH., DC			25a. DATE REC'D. BY REGISTRAR JULY 28, 1987		25b. REGISTRAR'S SIGNATURE						

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Look at this



REG. NO.

20499

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be checked for use as the burial permit. If you do not wish to bury, cremation, or removal, with the State Dept. of Health and Mental Hygiene, or if there is any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or item 22 is checked, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																		
8 / 21 000 REG. NO.																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ALPHONSUS CARMEN RAGOZZINO												JULY 24 1987					1:46 P	
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH DAY YEAR AUGUST 2 1898			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.									
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY U.S.M.C.									
13a. STATE PENNSYLVANIA			13b. COUNTY			13c. CITY OR TOWN PHILADELPHIA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1245 MEDARY AVENUE 19141						
14. FATHER'S NAME FIRST MIDDLE LAST RAPHAELLE RAGOZZINO			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TERESA RUIOTO															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES 1920-1950			17. INFORMANT MARGARET J. GODDARD, STAR ROUTE #1, BOX 232,			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRIC CARCINOMA			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF			(c)			DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from JULY 20 19 87 to JULY 24 19 87, that (I) (we) last saw the deceased alive on JULY 24 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE D. E. LEWIS			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 27 July 87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. E. LEWIS, LT, MC, USNR			22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE July 28, 1987			23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VIRGINIA									
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME			ADDRESS SILVER SPRING, MARYLAND			25a. DATE REC'D. BY REGISTRAR AUG 3 1987			25b. REGISTRAR'S SIGNATURE Julia Gordon-Lindall									

104-204 203180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

062036 AUG

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO. 67-21001														
1. STATE REGISTRAR			2. NAME (TYPE OR PRINT)			3. SEX			4. RACE					
FOR			MARIA C. RAMIREZ			FEMALE			HISPANIC					
1-B-87														
5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. DATE OF DEATH			8. MONTH DAY YEAR					
MONTH 12 DAY 15 YEAR 41			45			07-31-87			10:45 AM					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12. USUAL OCCUPATION					
Cedros/Honduras			Takoma Park			(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			(TYPE OF WORK FOR MOST OF WORKING LIFE)					
13. STATE			14. COUNTY			15. CITY OR TOWN			16. KIND OF BUSINESS OR INDUSTRY					
Md.			Mont.			Takoma Park			Home Care					
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. FATHER'S NAME			19. MOTHER'S MOTHER'S MAIDEN NAME			20. STREET ADDRESS / ZIP CODE					
Montgomery			Pablo			Augustina			20912 New York Avenue					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			22. SOCIAL SECURITY NO.			23. INFORMANT			24. ADDRESS					
no			220-92-9285			Maria J. Ramirez			245 RivoAlto Dr. Miami Beach, Fla 33139					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reynhard Anselmy</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Hypertension</u>														
25. MEDICAL CERTIFICATION			26. DATE OF OPERATION			27. CONDITION FOR WHICH OPERATION WAS PERFORMED			28. AUTOPSY?			29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			35. LOCATION STREET CITY OR TOWN COUNTY STATE								
36. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H (we) (did) (did not) view the body after death.)														
37. SIGNATURE <u>R. H. OEB</u> DEGREE														
38. ATTENDING PHYSICIAN			39. MEDICAL DIRECTOR			40. STAFF PHYSICIAN			41. DATE SIGNED					
												7/31/87		
42. PHYSICIAN'S NAME (TYPE OR PRINT)			43. ADDRESS			44. NAME OF CEMETERY OR CREMATORIAL			45. LOCATION CITY OR TOWN			46. COUNTY STATE		
R. H. OEB			8830 Camryn St. S.E. Md 20910			Union Cemetery			Burtonsville			Mont. Md.		
47. BURIAL, CREMATION, REMOVAL (SPECIFY)			48. DATE			49. NAME OF CEMETERY OR CREMATORIAL			50. LOCATION CITY OR TOWN			51. COUNTY STATE		
Burial			8/3/87											
52. FUNERAL DIRECTOR NAME			53. DATE REC'D. BY REGISTRAR			54. REGISTRAR'S SIGNATURE								
Fleck Funeral Home, Inc. Laurel, Md. 20707			AUG 06 1987											

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR 6:30 AM	
MANCIA RANDOLPH			7 4 87	26. HOUR 6:30 AM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 7 4 45	6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	12b. KIND OF BUSINESS OR INDUSTRY GOV. & IND. DISTRICT	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital od Sil Spr			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) X-Ray Technician	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Sil Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 816 Easley Street/20910	
14. FATHER'S NAME FIRST Oscar	MIDDLE H	LAST Randolph	15. MOTHER'S MAIDEN NAME FIRST Marie	MIDDLE L	LAST Fernandez
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 579-62-0090	17. INFORMANT Linda A. Randolph/Washington, D.C. 20011	1328 Quincy Street, NW		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH CANCER OF THE ST		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Diabetes			Cellulitis, renal Failure		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>7/17</u> , 19 <u>87</u> , to <u>7/17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hector K. Collom, MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7-22-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hector K. Collom, MD	22e. ADDRESS 111 Spring St SE MD 20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 7-22-87	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	23d. LOCATION CITY OR TOWN Suitland, Prince Geo., Maryland	COUNTY	STATE
24. FUNERAL DIRECTOR NAME D.C. Funeral Services, Inc. P.O. Box 6771, Washington, D.C. 20020	25a. DATE REG'D. BY REGISTRAR JUL 24 1987	25b. REGISTRAR'S SIGNATURE John Bennett, D.C.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner should be notified or advised.

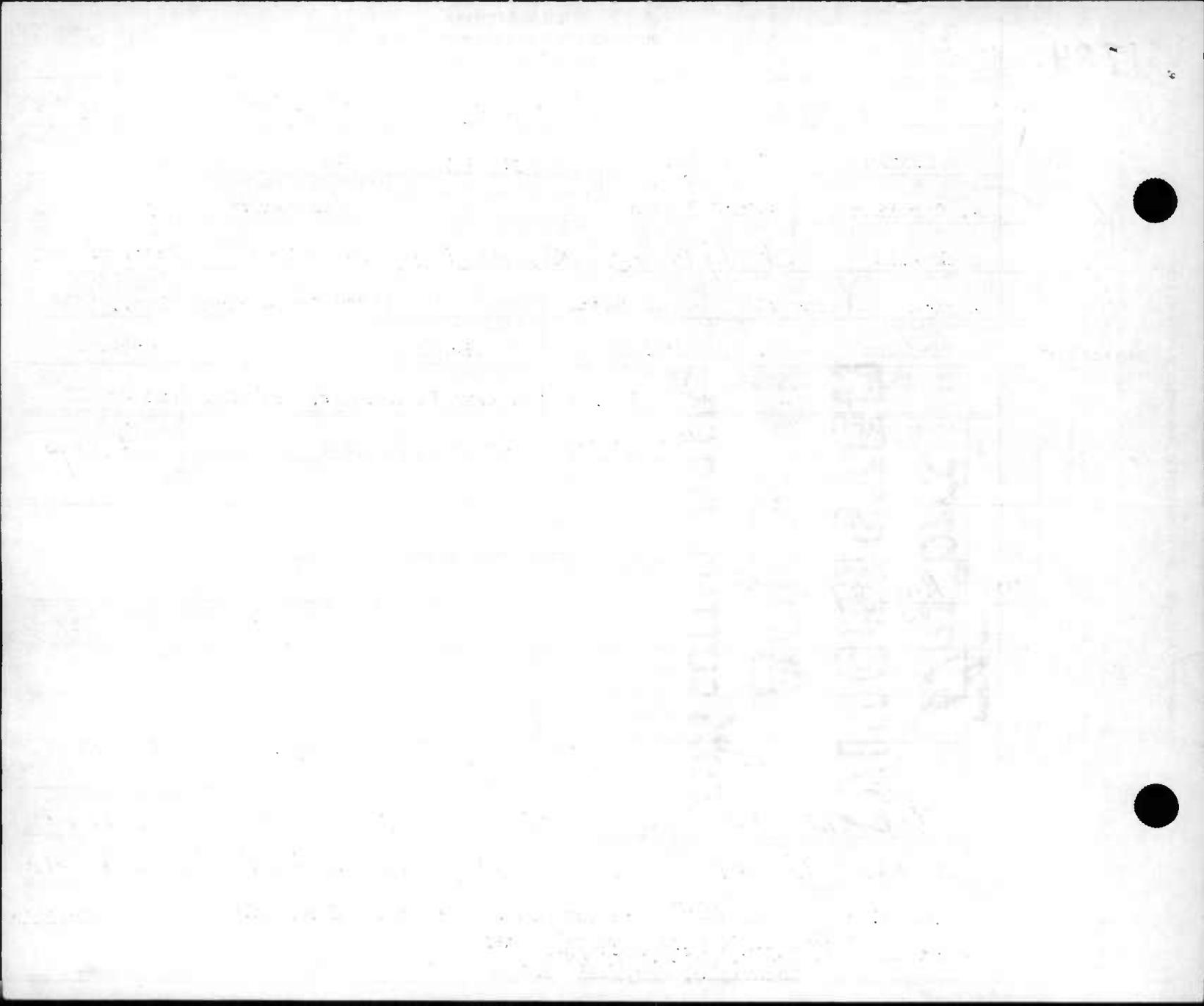
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other infirmity, enter the medical examiner's name in Item 21.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5121003						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Myra			I			Recknor						7/12/87					12 ¹⁵ AM	
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Caucasian			March 21, 1915						72		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
N. Carolina			United States									Montgomery County,						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Rockville			Shady Grove Adventist Hosp									Supervisor		Dept. of Navy				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		Zip: 32931- 4700 Ocean Beach Blvd., #5289				
Florida			Brevard			Cocoa Beach			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME						
Herbert			W.			Pollard						Minnie		Carawan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No			578-07-3105			Mr. Carl E. Recknor, Husband, Same as #13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Metastatic Ovarian Cancer												17 days						
DUE TO, OR AS A CONSEQUENCE OF (b)																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/12, 1987, to 7/12, 1987, that (I) (we) last saw the deceased alive on 7/12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
Allison Morris			MD						7-12-87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
Allison Morris			14905 Braschert Rd Rockville, Md															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Cremation			July 13, 1987			Metropolitan Crematory			Alexandria			JUL 15 1987		Jane Anderson Pendleton				
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours of the death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. The page retains carbon copies. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show only injury, or other traumatic event, the medical examiner in this state should be informed of the death.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 81004

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Samuel James Reese						May 8, 1987				4:02 p.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		December 10, 1929		57 yrs						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.		
Kentucky		USA				Montgomery County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		Clinical Center, NIH, Bethesda, Md				Painter				Home Improve.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland		Prince Geo.		Cheverly				3613 62nd Ave		20785		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Harold		Frank		Reese		Emily				Parks		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT				ADDRESS		
No		414-34-8375				918 5th Street Michael Brad Reese, Laurel, Md. 20707						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HOURS												
DUE TO, OR AS A CONSEQUENCE OF (b) HISTORY OF ACTH PRODUCING TUMOR												
DUE TO, OR AS A CONSEQUENCE OF (c) HISTORY OF PULMONARY DISEASE												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 6</u> , 19 <u>87</u> , to <u>May 8</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 8</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.												
22b. SIGNATURE <i>John R. Caughron MD</i>		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9 May 87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Caughron		22e. ADDRESS National Institutes Of Health, Clinical Center, 9000 Rockville Pk. Bethesda, Md 20892										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 15, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, P.G., Maryland		23e. COUNTY		STATE		
24. FUNERAL HOME NAME FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR 1111 27 1987		25b. REGISTRAR'S SIGNATURE <i>J. Deacon</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 and 2. It should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, it must be noted on the death certificate and filed with the certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																							
8 7 2 1 0 0 5 REG. NO.																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR					
DOROTHY VANBUSKIRK REIFENSTEIN												JULY 6 1987						8:20 P					
3. SEX		4. RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS								
FEMALE		CAUCASIAN		MONTH DAY YEAR						78			MONTHS DAYS		HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH			MD.										
ILLINOIS		UNITED STATES								MONTGOMERY													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
BETHESDA		NAVAL HOSPITAL										HOMEMAKER											
13a. STATE MARYLAND												13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4 SAVANNAH COURT 20817					
14. FATHER'S NAME FIRST WILLIAM TOBEY VANBUSKIRK MIDDLE LAST												15. MOTHER'S MAIDEN NAME FIRST GRACE BARBARA TRIBLE MIDDLE LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		ADDRESS																	
NO		559-68-4570		GEORGE H. REIFENSTEN, 4 SAVANNAH COURT, BETHESDA, MD 20817																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RENAL FAILURE</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 16</u> , 19 <u>87</u> , to <u>JULY 6</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JULY 6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>07 July 87</u>											
22b. SIGNATURE <u>R. P. Dolan MD</u>		22d. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																							
R. P. DOLAN, LT, MC, USNR																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE July 8, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria		COUNTY		STATE Virginia													
CREMATION																							
24. FUNERAL DIRECTOR NAME P.O. Box 43352 Washington, DC 20010		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 10 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Dolan-Lindall</u>																	

21-4050

21-4050

21-4050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be used.

completely filled in by hand and signed by the attending physician. It should be detached for use as the burial permit. Then please remove carbon copy and send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove carbon copy and send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other trauma.

MEDICAL CERTIFICATION

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7-19-87
REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
SEYMOUR					REISSMAN	JULY 19, 1987				6:15 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HR. HOURS	YRS	11. CITY OR TOWN OF DEATH	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Male	Caucasian	4-28-25				62				Silver Spring	Salesman (Retired)	Wholesale Drug
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH MD.								
New York	USA			Montgomery								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A NURSING HOME, GIVE STREET ADDRESS)					12c. STREET ADDRESS / ZIP CODE						
Silver Spring	The Fairland Nursing Home					2805 Harris Avenue (20902)						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. ADDRESS								
Maryland	Montgomery	Wheaton		Wheaton, Md. 20902								
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST					
	Max		Reissman	Dora			Fleck					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for Part 1b and 1c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
NO	116-14-0485	Shirley Reissman, Wife; 2805 Harris Avenue;										
DUE TO: OR AS A CONSEQUENCE OF (b) <u>Brain tumor</u>												
DUE TO: OR AS A CONSEQUENCE OF (c)												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b N/A												
19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7/18/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Luis A. Casas</u> DEGREE												
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED 7/19/87												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis A. Casas						22e. ADDRESS 8317 Cherry Ln. Laurel MD 20707						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/21/87	23c. NAME OF CEMETERY OR CREMATORIAL King David Mem. Garden			23d. LOCATION CITY OR TOWN Falls Church, Fairfax, Va.	23e. COUNTY STATE				
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPEL NAME 1170 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR 11/11/87	25b. REGISTRAR'S SIGNATURE Julie Danzansky-Goldberg					

18 32 JUL 27 1980

20% 80% 100%

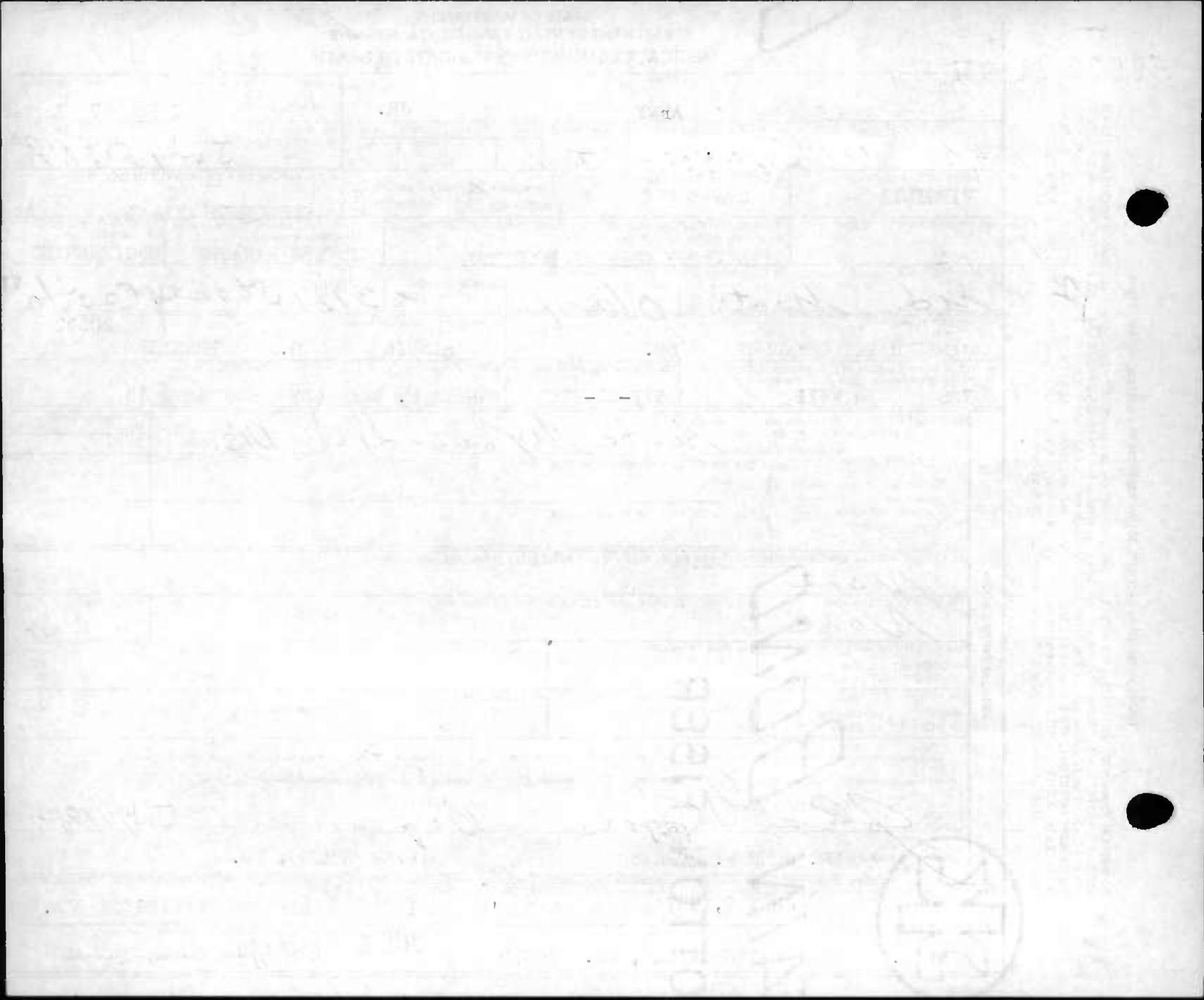
100% 80% 20%



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-100. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO. 59027 JUL 2 1987											1b. HOUR 1:00 AM
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH	DAY	YEAR
JAMES HARRY REYNOLDS JR.						JULY 5 1987					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7f. IF UNDER 1 YR. MONTHS	7f. IF UNDER 24 HRS. DAYS	7f. IF UNDER 24 HRS. HOURS	7f. IF UNDER 24 HRS. MIN	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR
MALE	BLACK	SEPT. 3, 1922	64 yrs.					July 5 1987			
7a. BIRTHPLACE (STATE OR COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH		
VIRGINIA			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTGOMERY COUNTY		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
OLNEY			MONTGOMERY GENERAL HOSPITAL			SYSTEMS MANAGER			ENGINEERING		
13a. STATE Md.			13b. COUNTY Mont.			13c. CITY OR TOWN Olney			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			13e. STREET ADDRESS 3727 Stoney Castle LAST 20832		
JAMES HARRY REYNOLDS			SR.			MINNIE G.			PERKINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES WWII			577-22-8283			GRETA M. REYNOLDS			SAME AS # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (o) <i>None</i>											
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
									COUNTY		
									STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER			DATE SHOWN <i>July 7 1987</i>		
EXAMINER'S NAME (TYPE OR PRINT)			DR. JOHN S. ROGERS			ADDRESS			SILVER SPRING, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		
BURIAL			JULY 9, 1987			ARLINGTON NAT'L CEMETERY			ARLINGTON COUNTY ARLINGTON STATE VA.		
24. FUNERAL DIRECTOR NAME MURIEL H. BARBER			ADDRESS LAYTONSVILLE, MD. 20879			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Landace</i>		
						JUL 8 1987					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

059630 JUL 16 1987
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/travel permit. Then place in envelope and mail to Burial or Mortuary removal.WITH IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.
18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 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634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000. 1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 111

negative

negative 400 81 100

Car and 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours of death with the State Dept. of Health and Mental Hygiene ~~and~~ ^{to} burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 / 21 009	REG. NO.				
1 - FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
1 - FOR STATE REGISTRAR			JANVIER — RICHARDS			LAST			7/24/87						9:59 P		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE			Caucasian			MONTH DAY YEAR			82			MONTHS	YEARS	MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
WASHINGTON, D.C.			USA									MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
BETHESDA			SUBURBAN HOSPITAL			None			None								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
MARYLAND			MONT. CO.			BETHESDA			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4400 GLADWYNE DRIVE / 20814					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Robert			M. RICHARDS			MINNIE			YES			578-18-4367			ADDRESS		
															4977 BATTERY LA. BETHESDA, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia</i>														
			DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-24</u> , 1987, to <u>7-24</u> , 1987, that (I) <input type="checkbox"/> last saw the deceased alive on <u>7-24</u> , 1987, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.																	
22b. SIGNATURE <i>John Janvier</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-24-87								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Janvier</i>			22e. ADDRESS 8218 WISCONSIN AVE BETHESDA														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE July 28, 1987			23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORIAL			23d. LOCATION CITY OR TOWN RIVERDALE PG Co. MARYLAND			25a. DATE REC'D. BY REGISTRAR AUG 3 1987			25b. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME SILVER SPRING, MD.			ADDRESS														

OB1625 VAG-485

RICHARD

JANET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8721010
REG. NO.

060483 JUL 23 1987

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial/transit permit. Then please stamp carbon papers. Pages 1 and 2 should be mailed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/transit, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified of death.

MEDICAL CERTIFICATION

DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR	2b HOUR								
Bienvenido G. Romero						7 16 87	12:34 PM								
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.							
Female	Caucasian	March 22, 1916	71												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Cuba	Cuba					Montgomery									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring	Holy Cross Hospital					Homemaker									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE									
Maryland	Montgomery	Takoma Park				8701 Barron Street #1 20912									
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Flores	Juana Maria Valdez														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO	578-88-9447	SON	Cardio Respiratory Arrest			133 Old Centerville					30'				
Ricardo Romero						Rd. Manasses, VA 22110									
DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Rhythm											30'				
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease											2 months				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Congestive Heart Failure, Pseudomembranous Colitis															
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 87 to 7-16 1987, that (I) (we) lost saw the deceased alive on 7-15-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22b. SIGNATURE R. I. m. w.	22c. DEGREE	22d. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS	6201 Greenbelt Rd, College Park, MD 20740								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE				
Burial			July 20, 1987	Gate of Heaven			Silver Spring		Montgomery		MD				
24. FUNERAL DIRECTOR NAME			Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
						1111 22 1987		Julia Deacon, R.N.							

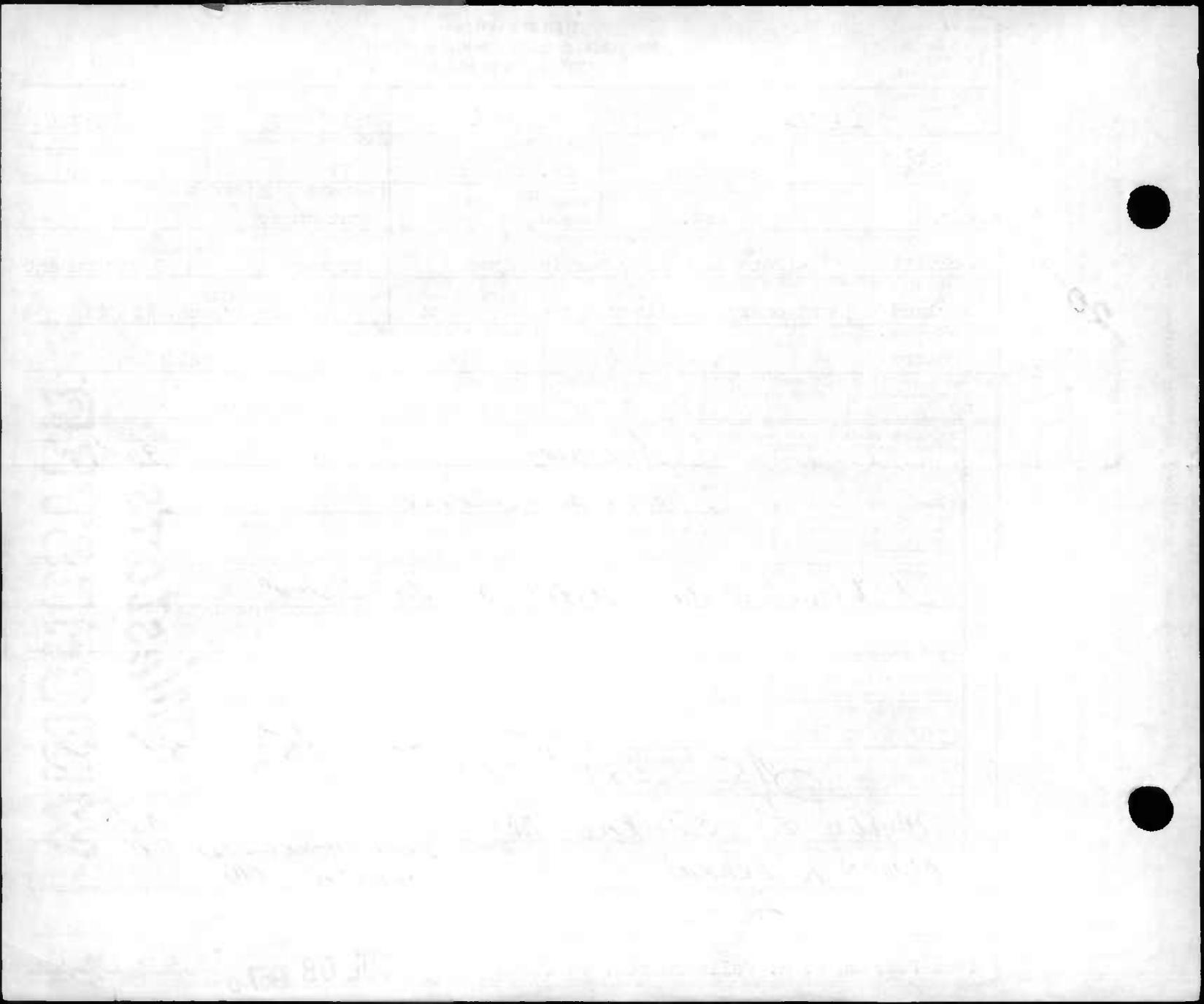
50 CS JUL 364030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 6121011									
1. FOR STATE REGISTRAR			2. DECEASED NAME			3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR			
			FIRST MIDDLE LAST			Male			Caucasian			MONTH DAY YEAR			77			9:30AM			
1. DECEASED NAME (TYPE OR PRINT)			LEON D. Rosdol			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland			7b. CITIZEN OF WHAT COUNTRY? USA.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney			12b. KIND OF BUSINESS OR INDUSTRY US Government												
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? ES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9502 Wire Avenue, 20901									
14. FATHER'S NAME FIRST MIDDLE LAST			Rosdol			15. MOTHER'S MAIDEN NAME Elke															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 124 05 5928			17. INFORMANT Minna Rosdol: See # 13 above															
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 day</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Decubitus ulcer</i>																					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular Disease</i>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Arteriosclerotic Cardiovascular Disease</i>																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>7125</i> CITY OR TOWN <i>86</i> COUNTY <i>75</i> STATE <i>87</i>															
22a. I certify that (I) (this hospital) attended the deceased from <i>7/25</i> to <i>8/19</i> , and that in (my) <i>0</i> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <i>0</i> the body after death.												22b. SIGNATURE <i>Myron L. Lenkin</i>		DEGREE <i>MD</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Myron L. Lenkin</i>			22e. ADDRESS 2309 MOREFIELD WHEATON MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22f. DATED SIGNED <i>7/25/87</i>												
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE July 7 1987			23c. NAME OF CEMETERY OR CREMATORIAL King David Mem'l Pk			23d. LOCATION CITY OR TOWN Falls Church, Va			23e. COUNTY STATE									
24. FUNERAL DIRECTOR NAME Ives-Pearson F. H. Falls Church, Va 22046												25a. DATE REC'D. BY REGISTRAR JUL 08 1987			25b. REGISTRAR'S SIGNATURE <i>John Davidson Pendleton</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR	
Mary			Rosenthal			7-22-87			1910 M										
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH July 8, 1896			6. AGE (IN YEARS LAST BIRTHDAY) 91			IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery									MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home												
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE 11200 Rockwood Drive 20902							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		15. MOTHER'S MAIDEN NAME Rachel			16. ADDRESS 18708 Bloomfield Dr., Olney, Maryland									LAST	
14. FATHER'S NAME FIRST Samuel		MIDDLE Markel		LAST		17. INFORMANT Nathan Rosenthal			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		16c. SOCIAL SECURITY NO. 578-03-9759		19. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Cancer of Ovary			19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
20a. DATE OF OPERATION 7/17/		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED 6A Ovary		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. INJURY WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b PART 1 OR PART 2)															
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 7/10/1987 to 7/22/1987, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 7/10/1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not <input type="checkbox"/> view the body after death.		22b. SIGNATURE H. Markel		22c. DEGREE M.B.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 7/22/87									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) H. MARTEL		22f. ADDRESS 7610 Cornell Ave Takoma Park, Md.																	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE July 24, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Hebrew Friendship Cemetery			23d. LOCATION TOWN			Baltimore, Maryland									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 1987-07-28		25b. REGISTRAR'S SIGNATURE Sia Scidmore-Lendar															
25c. ADDRESS Falls Church, Va. 22046																			

1005 JUL 3 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Forms 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																		
8 / 21013 REG. NO. 21013																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
Dorothy W. Ross												July 1, 1987					5:00 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Female			Caucasian			Month Day Year			66			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. YRS.		10. MONTH.				
Georgia			U.S.A.			May 5, 1921			Montgomery									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring			912 Robin Road						Secretary			Army Dept.						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland			Montgomery			Silver Spring			YES			912 Robin Road			20901			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
John Thomas			Whitfield			Rena			260-16-7396			Juan D. Ross Husband			Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
cardiorespiratory arrest												1 minute						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												due to, or as a consequence of (b) cachexia of cancer						
{												6 months						
due to, or as a consequence of (c) breast cancer												4½ years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6/17/83 to 7/1/87, that (I) (we) last saw the deceased alive on 6/17/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 7/2/87						
22b. SIGNATURE Bruce A. Silver, M.D.			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 6, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION CITY OR TOWN Rockville			COUNTY Montgomery		STATE Maryland				
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS			25a. DATE REC'D. BY REGISTRAR 1111 9 1987			25b. REGISTRAR'S SIGNATURE Julia D. Dinsen												
500 University Blvd. W. Silver Spring, Md. 20901																		

00:03

1991-1-101

6357

00:03:00

00:03:02 1991-2-1128 101-1007 Soniholt 1012

00:03:02 101-1008

060597 JUL 24 87

executed within 24 hours of death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the deceased be attended by the attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 21014

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	1	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
X EVERETT			ROSS				JULY 18, 1987			3:35AM M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS		
MALE		W		JUNE 8, 1926		61 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
OLNEY		U.S.A.		MONTGOMERY GENERAL HOSPITAL		MONTGOMERY COUNTY			CONSTRUCTION		
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.						13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING		
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			MINNER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
YES		231-16-4332		MONTGOMERY CO. GENERAL HOSPITAL							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC ENCEPHALOPATHY</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>ALCOHOLIC LIVER DISEASE</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>LUNG CANCER, ANEMIA</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 17, 1987, to JULY 18, 1987, that (I) (we) last saw the deceased alive on JULY 18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED					
22b. SIGNATURE <u>J. Michael Anchors MD</u>						DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. MICHAEL ANCHORS, M.D.</u>						22e. ADDRESS <u>9711 MEDICAL CENTER DR. SUITE 103 ROCKVILLE, MD 20850</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 7-20-87		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN			STATE	
24. FUNERAL DIRECTOR NAME STATE ANATOMY BOARD		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 22 1987			25b. REGISTRAR'S SIGNATURE <u>Julia Scidmore-Randall</u>				

08281 JUL 1984

188 22 JUL

061236 JUL 30 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 87 21015
1. DECEASED NAME (TYPE OR PRINT)		FIRST Karl	MIDDLE O.	LAST Rost	2a DATE OF DEATH MONTH 7 25 87
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1896	6. AGE (IN YEARS LAST BIRTHDAY) 90 IF UNDER 1 YEAR MONTHS YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? United States		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Vice Pres.
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Potomac	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 12301 Beall Spring Rd./20854
14. FATHER'S NAME FIRST Henry		MIDDLE Rost	LAST	15. MOTHER'S MAIDEN NAME FIRST Fredericka	MIDDLE LAST Weissert
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. I		17 INFORMANT Dorothy Kretzer, Same as # 13.	ADDRESS
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Serratus Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET <u>17904 Georgia Avenue</u>	CITY OR TOWN <u>Olney</u>	COUNTY <u>Maryland</u>
22a I certify that (I) (this hospital) attended the deceased from <u>July 24</u> 19 <u>87</u> to <u>July 26</u> 19 <u>87</u> , that (I) (not last saw the deceased alive on <u>July 24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (had) (did not) view the body after death.					
22b SIGNATURE <u>Thomas E. Dodge, M.D.</u>		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <u>July 25, 1987</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas E. Dodge, M.D.</u>		22e ADDRESS <u>17904 Georgia Avenue</u> <u>Olney, Maryland 20832</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 28, 1987	23c. NAME OF CEMETERY OR CREMATORIAL Hackensack Cemetery	23d LOCATION CITY OR TOWN Hackensack, New Jersey	STATE
24 FUNERAL DIRECTOR Robert A. Humphrey Funeral Home, Bethesda, Maryland 20814		RECD. BY REGISTRAR JUL 29 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Dardorff-Randall</u>		
DHHM - 16 60M 7/B4 (VRA 15, 4)					

061232 JUL 30 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, another traumatic event, the medical examiner must be pellied at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
REG. NO. 87 21016																
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ethel			MIDDLE R.			LAST Rowalt			2a. DATE OF DEATH MONTH JUN DAY 30 YEAR 1987 2b. HOUR 8:45				
3. SEX Female			4. RACE WHITE			5. DATE OF BIRTH MONTH February DAY 2, YEAR 1902			6. AGE (IN YEARS LAST BIRTHDAY) 85			IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 8 MIN. 45		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY New Hampshire			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT HOSPITAL FACILITY GIVE STREET ADDRESS - Grosvenor Health Care Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher			12b. KIND OF BUSINESS OR INDUSTRY M.C.P.S.S.							
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9337 Columbia Blvd. 20901				
14. FATHER'S NAME FIRST Unknown			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Unknown			MIDDLE			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO 217-34-1937			17. INFORMANT SON			ADDRESS 537 Deep Run Pkwy			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
									Russell Rowalt			Elkridge, MD 21227				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio Respiratory arrest 9 mins.</u>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost (b) <u>coronary arterio sclerosis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years				
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Chronic Bronchitis syndrome</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-29 1987 to 6-30 1987, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 5-29 1987, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.																
22b. SIGNATURE <u>John Tauber MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-30 87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber			22e. ADDRESS 8218 WISCONSIN AVE Bethesda													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE July 3, 1987			23c. NAME OF CEMETERY OR CREMATORIAL George Washington			23d. LOCATION CITY OR TOWN Adelphi			COUNTY Prince Georges		STATE MD		
24. FUNERAL DIRECTOR NAME Francis J. Collins Jr. 500 University Blvd., W Silver Spring, MD 20901						25a. DATE REC'D. BY REGISTRAR JUL 13 1987			25b. REGISTRAR'S SIGNATURE							

same terms, protection and a 2000

year extension to the guarantee

and not less than 2000

X

187000 re 1000000

Contract

187000 re 1000000 not to be

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL Cremation.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1- STATE REGISTRAR		REG. NO. 87 21017													
2- DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		2b. HOUR MONTH DAY YEAR					
Richard Mayo Rowell								<input checked="" type="checkbox"/> 7-17- 1987		M					
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.					
Male		White		July 20, 1940		46 yrs.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Massachusetts		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Montgomery County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK)			
Takoma Park		Rear of 7525 Carroll Avenue										12b. KIND OF BUSINESS Computer Programming			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS							
Maryland		Montgomery		Rockville				1906 Valley Stream Drive 20850							
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME									
FIRST Walter		H.		Rowell		FIRST Priscilla		MIDDLE		LAST Mayo					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		012-32-5450		PerisC. Rowell (wife)		same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? HEAD ONLY			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		Self inflicted Rear 7525 Carroll Ave. Takoma Park, Montgomery Co., MD									
22a. I certify that I had charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Charles P. Kokes</i> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Baltimore, MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/21/87		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria, Virginia		23e. STATE							
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852															
25a. DATE REC'D. BY REGISTRAR JUL 22 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Danner-Kandee</i>													

18 ES JUL 10 10 00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												RECD. NO. 87-21018
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH	YEAR	1b. HOUR	
ROBIN LYNN ROYLE						<input type="checkbox"/>			7-4-	1987		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	2d. HOUR	
Female	Caucasian	March 25, 1954	33 yrs.			<input type="checkbox"/>			7-4-	1987	1:00 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
California			United States						Montgomery County MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Rockville Pike and Alta Vista			Travel Agent			Travel			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
		Washington, DC						1316 New Hampshire Ave NW #B-1				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
J. C. Royle			JoAnne Caris									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Sister)			ADDRESS			
No N/A			549-06-1657			Patricia J. Royal-Burd, St. Sumter, S.C.			434 West Calhoun			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, QR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, QR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 19a. DATE OF OPERATION												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> QR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 12:45 AM 7-4-87			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Bicycle rider struck by motor vehicle						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET Rockville Pike and Alta Vista, Bethesda, CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE			M.D. Deputy Chief MEDICAL EXAMINER			TITLE (SPECIFY)			DATE SIGNED 7-4-87			
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria			
Cremation			July 7, 1987						COUNTY STATE Virginia			
24. FUNERAL DIRECTOR NAME			Richard Rapp, Inc., P.O. Box 43352			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
						JUL 13 1987						
999999												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Death certificate page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate is signed by the attending physician and completely filled in, it should be detached for use as the burial from. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene, and the third page should be filed with the medical examiner. If item 21 is marked "No", attach a copy of the death certificate to the burial or cremation or removal.

IMPORTANT: If item 21 is marked "No", attach a copy of the death certificate to the burial or cremation or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 / REG. NO. 21019												
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH		2b. HOUR	
Verna			L.			Royle			July 30, 1987		4:45 A.M.	
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR Nov. 13 1881			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Care Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Montgomery			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. STREET ADDRESS / ZIP CODE 15107 Interlocken Dr, 20906			
15. FATHER'S NAME Charles			16. MIDDLE Welch			15. MOTHER'S MAIDEN NAME Esther			16. MIDDLE Crittenden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. F214-36-3487			17. INFORMANT Mrs. Esther Coffman (Same as #13 above)			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis 10 yrs</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6-16 1987</u> , and that in <u>68</u> to <u>7-30 1987</u> , that <u>we</u> lost saw the deceased alive on <u>6-16 1987</u> , and that in <u>68</u> (our) opinion death occurred on the date and hour and from the causes stated in item 18. (I) (We) did not view the body after death.												
22b. SIGNATURE <u>George Sengstack, M.D.</u>			22c. DATE SIGNED July 30, 1987									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Sengstack, M.D.			22e. ADDRESS 3929 Ferrar Drive - Wheaton, Md. 20901									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-3-1987			23c. NAME OF CEMETERY OR CREMATORIAL Geo. Washington			23d. LOCATION CITY OR TOWN Adelphi, Pr. Co. Geo., Maryland			
24. FUNERAL DIRECTOR NAME Takoma Funeral Home Washington, D.C.			24b. ADDRESS Carroll St, N.W.			25a. DATE REC'D. BY REGISTRAR AUG 3 1987			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

104-204 242100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. When 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event,

060475 JUL 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 21020

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
Benjamin CHARLES Rubin				7-20-1987				5:45 A					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male	White	MONTH	DAY	YEAR	84	YRS.	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.					
Russia	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County,									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (Ret.)				12b. KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKERS) INDUSTRY				
Rockville	HEBREW HOME of Greater Washington, Business Owner				(20814)				Textile				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				LAST				
MD	MONTGOMERY	Bethesda	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4977 Battery Lane, #501-N				MARCUS				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.				ADDRESS			
HYMAN				IDA		086-050503				Potomac, Md. 20854			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(IF YES, GIVE WAR OR DATES)				Linda Greenhouse; Daughter; 10009 Ormond Road;				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				CARO/19c ARREST	
NO								DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN COUNTY STATE				
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 9/9, 1985, to 7/20, 1987, that <input type="checkbox"/> (we) last saw the deceased alive on 7/19, 1987, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE Alan Chanader				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 7/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Chanader				22e. ADDRESS 15225 SHADY GROVE RD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 7/21/87		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN Falls Church; Fairfax, Va.		COUNTY STATE					
24. FUNERAL DIRECTOR NAME		DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR 1111 22 1987		25b. REGISTRAR'S SIGNATURE Julia David-Lindsey							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be

remained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this death certificate is completed and signed by the attending physician and completed, it should be forwarded for use as the burial permit. Then, please remove carbon paper. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene, or to the funeral director, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Hazel J. Ruhling						July 25, 1987				3:00	A	
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			Caucasian	MONTH	DAY	YEAR	87			MONTHS	YEARS	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?	8			9			IF UNDER 24 HRS		
Illinois			United States	MARRIED	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	DIVORCED	<input checked="" type="checkbox"/>	YRS.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			6005 Johnson Avenue			Homemaker			Own Home			
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6005 Johnson Avenue/20817				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
John				Olson	Annie				Peterson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
No			577-84-1588			Charles A. Hoagland			9606 Page Avenue Bethesda, MD 20814			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma breast with multiple metastases</u> 2 yr. 8 mos.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION 11/29/84												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca breast			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 6, 1965</u> to <u>July 25, 1987</u> , that (I) (we) lost saw the deceased alive on <u>July 9, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Lewis N. Cahill</u> M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED July 27, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis N. Cahill, M.D.			22e. ADDRESS 5411 Cedar Lane Bethesda, Maryland 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 30, 1987	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Mem. Park			23d. LOCATION CITY OR TOWN Rockville, Maryland			COUNTY	STATE	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814			25a. DATE REC'D. BY REGISTRAR AUG 3 1987			25b. REGISTRAR'S SIGNATURE <u>Lewis N. Cahill, M.D.</u>						

TO A-20A 338100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Certificate remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene or with the funeral director. If death is caused by an injury or other traumatic event, the medical examiner may be notified.

IMPORTANT: If Item 21 is ministered or Item 18 shows any religious preference, attach a separate sheet.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Margaret K Russell						7/10/87			3404 M		
3. SEX Female			4 RACE Black			5. DATE OF BIRTH MONTH 11 DAY 11 YEAR 80			6. AGE (IN YEARS LAST BIRTHDAY) 160		
7a BIRTHPLACE (STATE OR FOREIGN MARYLAND)			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a STATE MD			13b COUNTY Montgomery			13c CITY OR TOWN Silver Spring			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST FRANK WYKOFF						15. MOTHER'S MAIDEN NAME LILLIAN PETERSON					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b SOCIAL SECURITY NO.			17 INFORMANT ANITA MAYO 2952 Carolton Ave. N.E.			Washington, D.C. 20018		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Pulmonary Insufficiency (c) <i>Congestive heart (small cell)</i> DUE TO, OR AS A CONSEQUENCE OF Congestive heart (small cell) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 54 6 hrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
22a. I certify that (I) (this hospital) attended the deceased from 5/19/87 to 7/10/87, that (I) (we) last saw the deceased alive on 5/19/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edgar H. LEV</i>						DEGREE			22c. DATE SIGNED 7/10/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEV M.D.			22e. ADDRESS 2801 Georgia Ave.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7-14-1987			23c. NAME OF CEMETERY OR CREMATORIAL BREWER HILL CEM.			23d. LOCATION CITY OR TOWN Annapolis A.A. Maryland		
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.			25a. DATE REC'D. BY REGISTRAR JUL 17 1987			25b. REGISTRAR'S SIGNATURE <i>Alia Davidson-Panduro</i>					
DHMH - 16 60M 7/84 (VRA 15, 4)											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3
retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completed, it should be detached for use as the burial-troune permit. Then please remove carbon papers. Pages 1 and 2 should be filled in within 72 hours after death, with the State Dept. of Health and Mental Hygiene, Death and Burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 is checked, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. STATE REGISTRAR			2. DECEASED NAME			3. DATE OF DEATH			4. REG. NO.		
			FIRST MIDDLE LAST			MONTH DAY YEAR			2.1 2.2 2.3		
1. DECEASED NAME (TYPE OR PRINT)			DEVIN PATRICK RYAN			NOVEMBER 29, 1980			July 28, 1987		
3. RACE			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
MALE			WHITE			MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
ILLINOIS			USA						MONTGOMERY CO. MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING			14211 GEORGIA AVENUE APT #101			13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		
13c. CITY OR TOWN SILVER SPRING						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 14211 GEORGIA AVE. #101 / 20906		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO			17. INFORMANT		
JOSEPH A. RYAN			DORIS M HUNTLEY			16b. SOCIAL SECURITY NO. 329-70-9728			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b)			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			Central Nervous System Depression			12 hours					
{			DUE TO, OR AS A CONSEQUENCE OF (c)			11 months					
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that (I) (this hospital) attended the deceased from 7-28, 1987, to X, 1987, that (I) (we) last saw the deceased alive on Never Seen Alive, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Larry Cotten, MD			DEGREE			22c. DATE SIGNED July 28, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
LARRY COTTEN, MD.			10313 GEORGIA AVE. SILVER SPRING, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____		
BURIAL			July 31, 1987			QUEEN OF HEAVEN Cemetery			HILLSIDE CEM. CHICAGO, ILLINOIS		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRATION SIGNATURE		
W. W. Chambers Co. 8655 Georgia Ave, Md. 20910			Silver Spring			AUG 31 1987					

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITALIC, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT FORM, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, OR Removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	26. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	28. HOUR
Jane Frances Ryan							<input checked="" type="checkbox"/>	7	10	87	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	27. DATE PRONOUNCED DEAD			
female	Caucasian	Dec 7, 1935	51					MONTH	DAY	YEAR	29. HOUR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Massachusetts		United States						Montgomery County, MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		1380 Kersey Lane				Agent				Insurance	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1380 Kersey Lane, 20854			
14. FATHER'S NAME FIRST C.		MIDDLE W.		LAST Hagerton		15. MOTHER'S MAIDEN NAME FIRST not available		MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS Sherman Oaks, Calif. 21423		17. INFORMANT Patricia Lee Ryan, 4422 Stern Av.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Hypertensive cardiovascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I was in charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 7/11/87	
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D.				ADDRESS 111 Penn St. Balto. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE July 13, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria,		COUNTY		STATE Virginia	
24. FUNERAL DIRECTOR Rockville, Inc., 300 W. Montgomery Ave. Rockville, Md. 20850						25a. DATE REC'D. BY REGISTRAR JUL 16 1987		25b. REGISTRAR'S SIGNATURE John S. Kokes, M.D.			

022203 JUL 1980



061839 AUG 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENNSYLVANIA" IN PENCIL IN ITEM 18. GIVE PAGES 1 & 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3, BURIAL TRANSIT PERMIT. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED				9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia		USA		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED				Montgomery MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
Salisbury		8044 Crace Hosp.		Vendor				Self/Emp.
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md		Montgomery	Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4715 Aspinwall Rd	
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST			
William D. Richardson					Caddy J. Nelson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No		577 056 946		Kenneth Hyland		3132 Christine Dr. Beltsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyper Gastrointestinal Bleeding</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to the immediate cause (a) stating the <u>underlying cause last</u> . (b) <i>Cirrhosis of Liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>External Abuse</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>								
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John D. Rogers</i>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8/4/1987		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, Maryland		
24. FUNERAL DIRECTOR NAME		Rendon/Hale Lanham Fun'l Home 9013 Annapolis Rd. Lanham, Md. 20706		25a. DATE REC'D. BY REGISTRAR AUG 4 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randalls</i>	

081833 202-291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, give it to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 6 21026	REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
YADA E. SALMON												7 18 - 1987						8:45 AM	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 9 DAY 12 YEAR 11			6. AGE (IN YEARS LAST BIRTHDAY) 75			7. IF UNDER 1 YEAR YRS.			8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH County Montgomery MD.										
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Grosvenor Health Care Center Nurse			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY Hospital										
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5721 Grosvenor Lane/20814							
14. FATHER'S NAME FIRST Furman			MIDDLE L.			LAST Bobo			15. MOTHER'S MAIDEN NAME FIRST Maude			MIDDLE LAST Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 225-16-8223			17. INFORMANT Frances B. Lawyer			ADDRESS 19105 Rhodes Way Gaithersburg, MD										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastatic carcinoma</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. 19a. DATE OF OPERATION												20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7-18-87</u> to <u>7-18-87</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>7-18-87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.												22e. DATE SIGNED <u>7-18-87</u>							
22b. SIGNATURE <u>John Tomber</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John Tomber</u>				22e. ADDRESS <u>Bethesda, MD. 8218 WISCONSIN AVE</u>															
23a. BURIAL, CREMATION, REMOVAL IS PREPARED Burial				23b. DATE July 21, 1987				23c. NAME OF CEMETERY OR CREMATORIAL Cemetery				23d. LOCATION CITY OR TOWN Suffolk, Virginia							
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 557 WISCONSIN AVE. BETHESDA, MD 20814								25a. DATE REC'D. BY REGISTRAR <u>JUL 21 1987</u>				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Lindsey</u>							

660326 MSS 81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21021
REG. NO.

061059 JUL 29 87

FOR
1- STATE
REGISTRAR

NAME
(TYPE OR PRINT)

Gladys
Gladys

Jean
Jean

LAST
SALYERS
Salyers

2a DATE KNOWN
OF
DEATH MATED

July 28 1987
M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENALTY" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, "MEDICAL EXAMINER'S PERMIT FOR AUTOPSY, TRANSIT, OR Cremation." TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A VITAL RECORDS TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

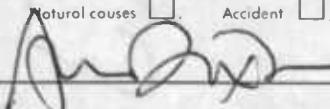
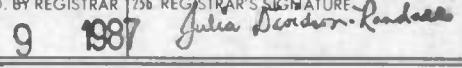
3. SEX Female	4. RACE White	5. DATE OF BIRTH MEDIUM DAY YEAR April 16 1927	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 71	7a. IF UNDER 1 YR. MONTHS DAYS HOURS MIN 7b. DATE MONTH DAY YEAR July 28 1987
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota		7d. CITIZEN OF WHAT COUNTRY? USA		7e. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Mont. Airy Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK) Housewife
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Henry		MIDDLE Dean	LAST Mary	15. MOTHER'S MAIDEN NAME White
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 226-05-8472 D		17. INFORMANT ADDRESS Larry R. Salyers, Mt. Airy, Md. 21771
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: 887		IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION 2-3-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fract 1. hip.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Home	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home	21f. LOCATION STREET 4213 Bill Moxley Rd. CITY OR TOWN Mt. Airy COUNTY Howard STATE Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE John S. Rogers, M.D.				
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 28, 1987	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet	23d. LOCATION CITY OR TOWN Frederick, Frederick, Md.
24. FUNERAL DIRECTOR Name Olin L. Molesworth, P.A., Damascus, Md.		25a. DATE REC'D. BY REGISTRAR JUL 28 1987		25b. REGISTRAR'S SIGNATURE John S. Rogers

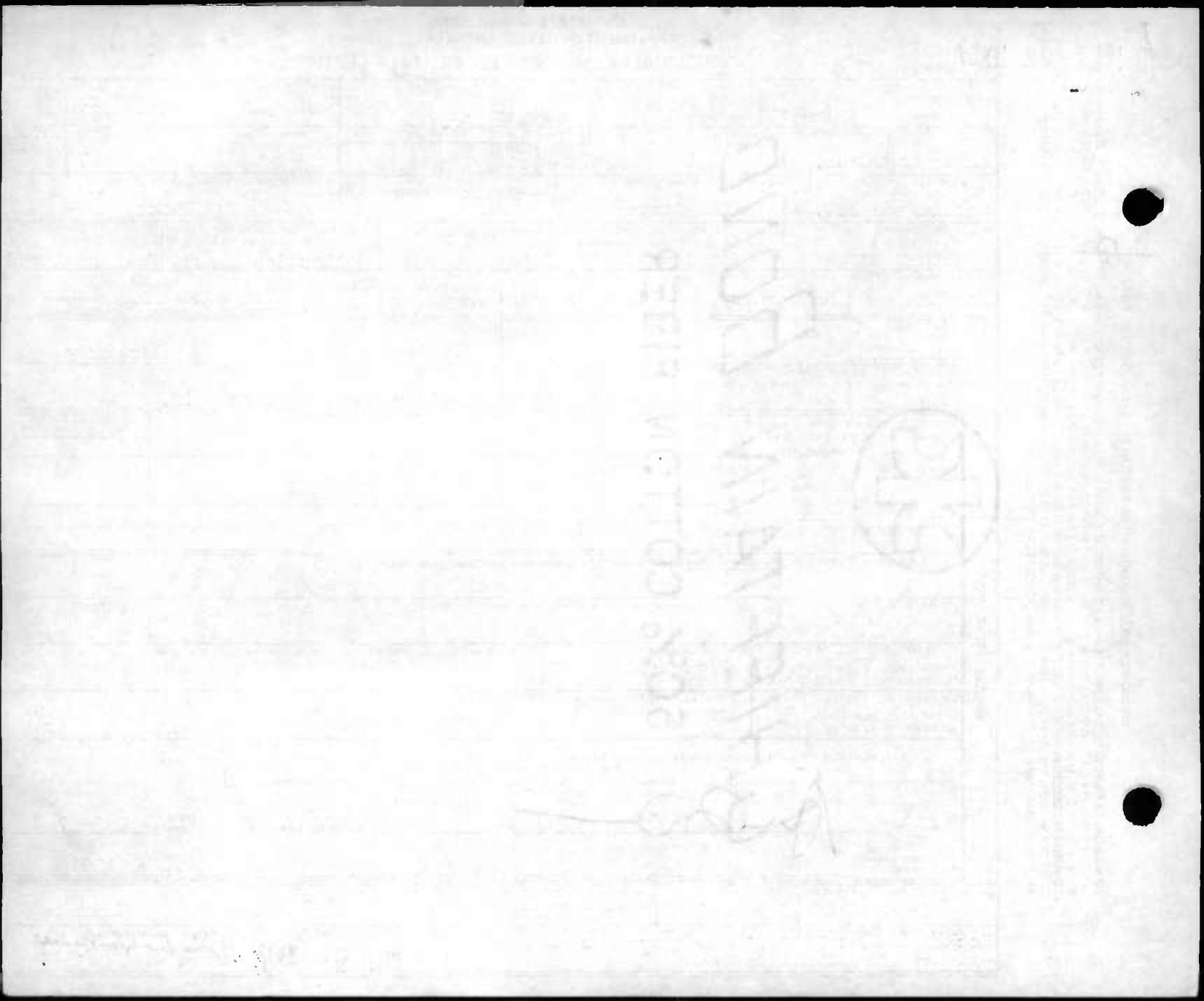
001023 00 5931

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21028
REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
Russell					Sams Jr.	<input checked="" type="checkbox"/>	7-4-	19	87	M		
3 SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
Male	Cauc.	July 5, 1939	47 YRS.			7-4-	19	87	M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington, D.C.		United States			Montgomery County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Gaithersburg		48 West Deer Park Drive			Collection Agent			Self-Employed				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		MD.			
Maryland		Montgomery		Gaithersburg			48 W. Deer Park Drive/20877					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Russell				Sams, Sr.	Helen				Humphrey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
No		229-48-8646			Jennifer Sams, Same as # 13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of head</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>												
(b) _____ DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 4:45 PM 7-4-87			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) Subject shot self							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION 48 West Deer Park, Gaithersburg, Montgomery County, MD							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 												
TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER												
DATE SIGNED 7-5-87												
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.			ADDRESS 111 Penn Street, Balto., MD21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Cremation July 7, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria			STATE COUNTY Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, Rockville, Inc 300 W. Montgomery Avenue Rockville, Maryland 20850								25b. DATE REC'D. BY REGISTRAR 1987			25c. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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9

1

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21029						
1. DECEASED NAME (TYPE OR PRINT)			FIRST Evelyn		MIDDLE		LAST Saylor		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
2. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
Female			White		MONTH 8 DAY 6 YEAR 09		77 YRS		MONTHS		DAYS		HOURS MIN.			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			AD						
Wash., D.C.			U.S.A.				Montgomery									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Kensington			Kensington Gardens		Photo Touch Up		Photography									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE									
—			—		Wash., D.C.		3201 Wisconsin Ave, NW/20016									
14. FATHER'S NAME			15. MOTHER'S MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
FIRST Zebedue			LAST Allison		578-03-6961		Lewis Armstrong, 67 S. Paula St., Laurel, MD									
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18d. DUE TO, OR AS A CONSEQUENCE OF (b)		18e. DUE TO, OR AS A CONSEQUENCE OF (c)							
No			—		Cardiorespiratory Arrest		Aspiration		Pneumonia							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7-1 1987 to 7-22 1987, that (I) () lost saw the deceased alive on 7-14 1987, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did) () view the body after death.																
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7-22-87						
John G. Gawler		John G. Gawler		John G. Gawler		8218 Wisconsin Ave										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE						
Burial		7/24/87		National Memorial Park		Falls Church, VA										
24. FUNERAL DIRECTOR NAME		Joseph Gawler's Sons, Inc.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
5130 Wisconsin Ave, NW, Washington, D.C.				20016		JUL 27 1987										

80828 Jul 28 1968

Major Major

	date	time	route
Photo copy up	x	U.S.A.	Map, D.C.
Reimbursement	x	U.S.A.	Map, D.C.
3501 McCormick Ave, MD 20016	x	Map, D.C.	Map, D.C.

PTPA	--	Map	Map	Map
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3501 McCormick Ave, MD 20016	1968-05-26-01	1968-05-26-01	1968-05-26-01	Map
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x

3501 McCormick Ave, MD 20016
Style Church, AV
Reimbursable expenses, Inc.
3501 McCormick Ave, MD 20016

59398 JUL 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other traumatic event. The medical examiner must be notified.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21030	REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR									
Bennett			R.			Scarff						July 9, 1987				9:10 P M									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS													
Male		Caucasian		October 8, 1904			82			MONTHS	YEARS	HOURS	MIN.												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.															
Maryland		United States					Montgomery County																		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																		
Chevy Chase		Bethesda Retirement Center		Founder/Owner			Appliance & Service																		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
												Maryland				Montgomery		Chevy Chase					8101 Connecticut Ave 20815		
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST																
John		Edmond		Florence								Hardigan													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. ADDRESS																		
No		578-42-5280		J. Dennis Scarff			11300 Skipwith Lane					Potomac, Maryland 20854													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a) Respiratory Failure																									
DUE TO, OR AS A CONSEQUENCE OF																									
(b) Bronchiolitis Obliterans												6 months													
DUE TO, OR AS A CONSEQUENCE OF																									
(c) Relapsing Polychondritis												1 year													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																									
Diabetes Mellitus																									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE														
22a. I certify that (1) <input type="checkbox"/> (the hospital) attended the deceased from June 19, 1986, to July 9, 1987, that (1) <input type="checkbox"/> (we) last saw the deceased alive on June 29th 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> (we) <input type="checkbox"/> (did) (did not) view the body after death.		22b. SIGNATURE David V. Young		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		4530 Connecticut Avenue, NW Washington, D.C. 20008							July 9, 1987														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE														
Burial		July 18, 1987		Gate of Heaven Cemetery			Silver Spring				Maryland														
24. FUNERAL DIRECTOR		Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave., Bethesda, Maryland 20814					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																
							JUL 13 1987																		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and attach to the burial permit. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the deceased.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other cause of death, the medical examiner must be consulted or contact the medical examiner's office at 301-587-5500.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21031

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			BRUCE STUART SCHOENBERG			JULY 14 1987			4:30 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		MONTH NOVEMBER DAY 2 YEAR 1942		44		MONTHS		DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
NEW JERSEY		UNITED STATES				MONTGOMERY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		SERVICE			
BETHESDA		NAVAL HOSPITAL		RETIRED		PUBLIC HEALTH					
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8520 HAZELWOOD DRIVE 20814			
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		BEATRICE BRODSKY					
MITCHELL SCHOENBERG											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES)		17. INFORMANT		ADDRESS					
YES		1968-1987		153-34-4794		DEVERA G. SCHOENBERG, 8520 HAZELWOOD DRIVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				BETHESDA, MD 20814				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)				ADENOCARCINOMA OF COLON							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).		DUE TO, OR AS A CONSEQUENCE OF (b)									
		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF YES, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 14 1987, to JULY 14 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. M. Keating</i> MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 14 July 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		NAVAL HOSPITAL							
R. M. KEATING, LT, MC, USNR						BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE July 16, 1987		23c. NAME OF CEMETERY OR CREMATORIUM Metropolitan Crematory		23d. LOCATION Alexandria, Va.					
24. FUNERAL DIRECTOR NAME		Ives-Pearson Funeral Homes Falls Church, Va. 22046		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Jul 17 1987 <i>Julia Doidor-Randall</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene or other traumatic event, the medical examiner should be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 has a question mark, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21032

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Alfred			M.	Schwartz		July	8	1987	8:30A		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		Mar. 14, 1899		88		YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
DC		U.S.A.				Montgomery County		MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Carriage Hill - Bethesda		Trial Lawyer		Self					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20008-99999	
DC		N/A		Washington		YES <input checked="" type="checkbox"/>		4501 CT Ave. NW Apt. 519			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
William		Schwartz				Ida		Rosa		Sonnanberg	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		WW I		579-52-2755		Katherine Schwartz Same as item # 13		5 years.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure - chronic.</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Anemia 20% Renal failure - severe</i>								20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I or my hospital) attended the deceased from so as the deceased died on 1987 to 1987, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. I have signed below to view the body after death.		22b. SIGNATURE <i>Blaine Fitzgerald, M.D.</i>		22c. DECEASED		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 7/18/87			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		8218 WI Ave. Beth., MD 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREAMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		7/10/87		Adas Israel Cem.		Wash., DC					
24. FUNERAL DIRECTOR NAME		Joseph Gawler's Sons, Inc.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		5130 WI Ave. NW Wash., DC 20016				JUL 13 1987		<i>Lia Daidon-Randall</i>			

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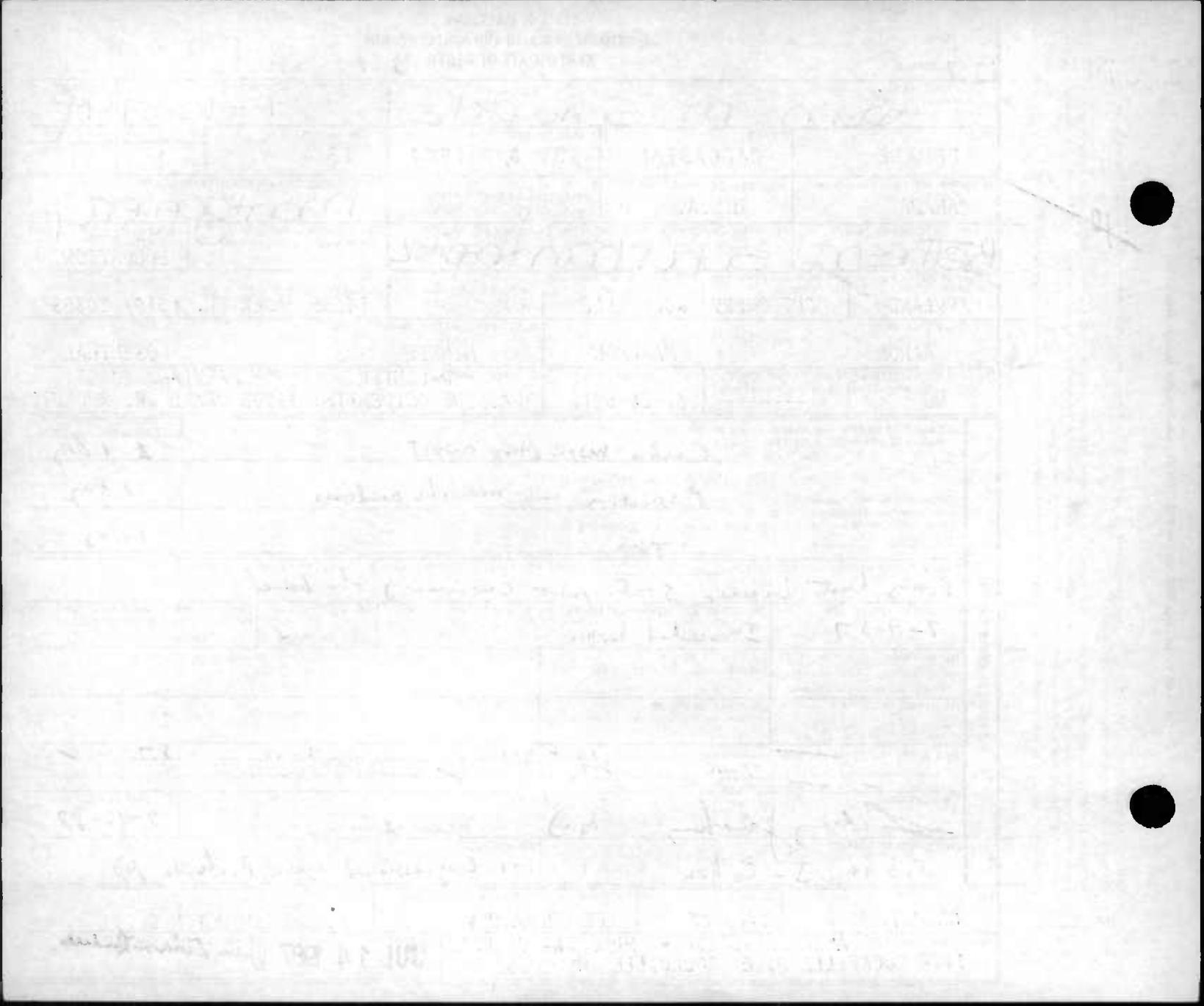
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(INFORMANT): If item 21 is marked on item 8, show any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 21030						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	IN HOME		
Sean M Schwartz												7-10-87				945 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
FEMALE			CAUCASIAN			MAY 8 DAY 1904			83			MONTHS DAYS			HOURS MIN.			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			19. BALTIMORE CITY OR COUNTY OF DEATH						
CANADA			U.S.A.									Montgomery			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING DAY)			12b. KIND OF BUSINESS OR INDUSTRY EDUCATION									
Bethesda			Suburban Hospital															
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
MARYLAND			MONTGOMERY			ROCKVILLE						14635 BAUER DR. #310/ 20853						
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME												
AARON			MARKSON			MINNIE						ROSENTHAL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
NO			061-28-5218			DAUGHTER MAURINE GOLDSMITH: 13705 DRAKE DR. ROCKVILLE			MARYLAND 20853									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			Cardio-respiratory arrest						3 days						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory and metabolic acidosis						1 day						
						DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis						1 day						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						Cirrhosis heart disease, Status post carcinoma of the bowel												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
7-9-87			Incurved hernia			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 10 + yrs. 19 to 7-10 19 87, that (I) (we) last saw the deceased alive on 7-10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE						DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
Sidney J. Cohen						M.D.						7-10-87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			121 Congressional Lane, Rockville, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN			COUNTY STATE						
CREMATION			7/13/87			LEE CREMATORIAL			N.E. WASHINGTON D.C.									
24. FUNERAL DIRECTOR			DANZANSKY-GOLDBERG MEMORIAL CHAPEL			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
			1170 ROCKVILLE PIKE: ROCKVILLE, MD 20852			JUL 14 1987			Julia Johnson									



|| within 24 hours after death Page 4 may be

HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed by the hospital or attending physician.

FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, it may be used as the burial permit. This is the only official document that should be used for the burial of the deceased.

IMPORTANT. If a name is handwritten, it should be initialed. If a name is typed, it should be signed by the typist.

BP _____
HMH - 16 60M 7/B
(VRA 15, 4)

DHMH - 16 60M 7/B4
(VRA 15 1)

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2103

1 - FOR
STATE
REGISTRATION

DECEDENT NAME (TYPE OR PRINT)			FIRST Robert	MIDDLE Adam	LAST Schwegel	2a. DATE OF DEATH MONTH DAY YEAR July 20, 1987	2b. HOUR 1:50 A.M.
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 27, 1967	6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE New Jersey		13b. COUNTY	13c. CITY OR TOWN Millville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 603 Mulberry		99999 08332
14. FATHER'S NAME FIRST James		MIDDLE Giammattéo	LAST	15. MOTHER'S MAIDEN NAME FIRST Diann		MIDDLE	LAST Schwegel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) NO		17. INFORMANT Mrs. Diann Giammattéo, Mother, Same Address		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Refractory Hypotension</u> 1 day							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Testicular Cancer</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 17, 1987</u> , to <u>July 20, 1987</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 20, 1987</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (will) view the body after death.							
22b. SIGNATURE <u>Steven M. Hollenberg</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>7-20-87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven M. Hollenberg</u>		22e. ADDRESS National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20892					
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Removal		23b. DATE 7-21-87	23c. NAME OF CEMETERY OR CREMATORIAL Cristy Funeral Home		23d. LOCATION CITY OR TOWN Millville	STATE N.J.	
24. FUNERAL DIRECTOR, MARSHALL'S FUNERAL HOME, INC. NAME 2119th Street, D.C. 20011		25a. DATE REC'D. BY REGISTRAR JUL 28 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Dawson-Burke</u>			

061668 VNC-2-81

060808 JUL

28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC. NO. 87 21035

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be

returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filled in by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then attach the removal carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or if there is a motor vehicle accident, the medical examiner must be informed.

MEDICAL CERTIFICATION

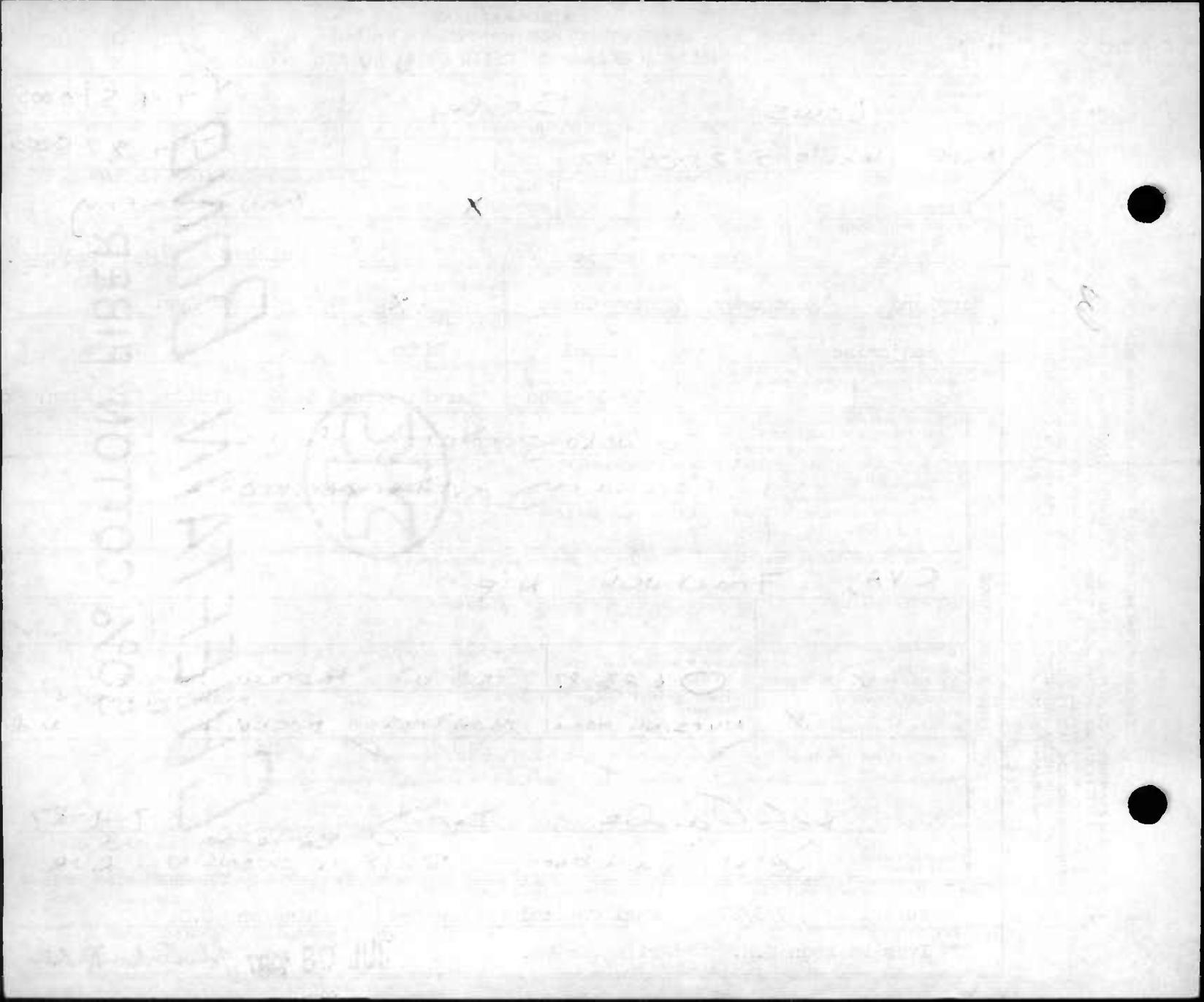
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
Zelma			V		Sebez	July	01	1987	3:05 PM			
3 SEX		4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)						
Female		Caucasian	MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
Latvia		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
Rockville		Collingswood Nursing Center			Ret. Nurses Aid					Nursing		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Silver Spring							14933 Wellwood Road 20904	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME (unknown)						
Janas				Sebez								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT					ADDRESS			
N/A		N/A 240-48-4240		Anita Terauds-niece- (same as 13e)								
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF (b) <u>massive stroke - left</u> BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>1 day</u> 1 month												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (o) <u>old right brain stroke</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 1987</u> to <u>7/21 1987</u> , that (I) (we) lost saw the deceased alive on <u>7/13 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (we) did not view the body after death.												
22b. SIGNATURE <u>Peter Sherer</u>		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22e. DATE SIGNED 7/21/87		
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS										
Peter Sherer MD		3947 Fernara Dr. Wheaton, MD 20906										
23a. BURIAL, CREMATION, REMOVAL (SPEC)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. STATE			
Cremation		7-22-1987		Metropolitan Crematory			Alexandria		Virginia			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.			25a. DATE RECEIVED BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Landau</u>					
BP												

00808025 JUL 28 1981



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 & 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21030			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Seidel			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH	DAY	YEAR	2b. HOUR
Louis									<input type="checkbox"/>			7	4	87	0205
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE Pronounced DEAD			
Male		White		5-25-05		82 yrs.		MONTHS		DAYS		MONTH			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			
Russia			USA.			<input checked="" type="checkbox"/>			<input type="checkbox"/>			Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda			Suburban Hospital			Ret; Butcher			Meat Package.						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Montgomery		Chevy Chase					4701 Willard Ave. 20815					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS						
Benjamine					Seidel	Rifka			Marvin Seidel 9806 Hillridge Dr. Kenn, Md						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			577-38-1660			Marvin Seidel									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART 1 DEATH WAS CAUSED BY:			CardioRespiratory arrest									
888			IMMEDIATE CAUSE (a)												
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			DUE TO, OR AS A CONSEQUENCE OF			Coronary arteriosclerosis									
(b)			DUE TO, OR AS A CONSEQUENCE OF												
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
CVA, Fractured Hip.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?						
									<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
			P.M. 6 23 1987			fell at Hebrew Home.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN						
			Nursing Home			Montrose			Montgomery Rockville Md.						
22a. I certify that I took charge of the remains described above, held an			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>												
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			TITLE (SPECIE) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 1-4-87						
EXAMINER'S NAME (TYPE OR PRINT)			John Tauber			8218 WISCONSIN Ave									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Burial			7/5/87			Nat'l Capitol Hebrew Cem			Washington, D.C.						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Ives-Pearson F.H.			Arlington Va.			JUL 08 1987			John Davidson-Randall						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified or one of the following should be done:

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						21037	
1. FOR STATE REGISTRAR			2. DATE OF DEATH			REG. NO.	
1a. DECEASED NAME (TYPE OR PRINT)	1b. FIRST	1c. MIDDLE	1d. LAST	2a. MONTH	2b. DAY	2c. YEAR	2d. HOUR
SARAH	F.		SEIGEL	JULY	31	1987	5:00A _m
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 29, 1907	6. AGE (IN YEARS LAST BIRTHDAY) 79	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY	10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3510 FOREST EDGE DRIVE	
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROCUREMENT OFFICER		12b. KIND OF BUSINESS OR INDUSTRY FEDERAL GOVERNMENT	
14. FATHER'S NAME FIRST ABBA	MIDDLE	LAST SILVERMAN	15. MOTHER'S MAIDEN NAME FIRST ETHEL	MIDDLE	LAST KAPLAN	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN NO	
16b. SOCIAL SECURITY NO. 577-20-5571		17. INFORMANT CHARLES J. FUTROVSKY, ADDRESS 923 KIMBERLY ROAD SILVER SPRING, MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) QUANINAN CAN SHOCK			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) MENSITRU CANCER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 AM			
		DUE TO, OR AS A CONSEQUENCE OF (c) QUANINAN CANCER		7 mos			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12 19 19 86 to 7/31 19 86, that (I) (we) last saw the deceased alive on 7/22 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stanley a Sch	22c. DEGREE	22d. ADDRESS 5454 WISCONSIN AVENUE CHEVY CHASE, MARYLAND				22e. DATE SIGNED 7/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. STANLEY SCHWARTZ, M. D.	22e. ADDRESS 5454 WISCONSIN AVENUE CHEVY CHASE, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 8/2/1987	23c. NAME OF CEMETERY OR CREMATORIAL MOUNT LEBANON CEMETERY	23d. LOCATION ADELPHI, PRINCE GEORGES, MD.				
24a. DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.	25a. DATE REC'D. BY REGISTRAR AUG 06 1987	25b. REGISTRAR'S SIGNATURE Julia Gordon-Readace					

062209 11 08 11 10

Items, 18a, 21a-22a., G-629, 7/25/87, by STATE OF MARYLAND
 FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1- STATE Med. Exam., / Gbj.
 REGISTRAR

21038
 REG. NO.

058164

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" ACROSS ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
Harry		W.		Sellers, Jr.	<input checked="" type="checkbox"/>	6/19/1987			M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.				
MALE	BLACK	MAY 3 32	55 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. DATE PRONOUNCED DEAD		2d. HOUR	
WASH D.C.		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		6/19/1987		6:05 P.M.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING WEEK)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				CARTOGRAPHER		MAPING	
13a. STATE MD.		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2307 PLYER MILL RD. 20902			
14. FATHER'S NAME FIRST HARRY		MIDDLE W.	LAST SELLERS SR.	15. MOTHER'S MAIDEN NAME ESTELLE		MIDDLE		LAST WATTS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. YES		16c. ADDRESS 1702 CROSBY RD. JACQUELINE SELLERS HYATTSVILLE MD:					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ethylene glycol intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:00 P.M. 6 15 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject took ethylene glycol					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 2307 Pliers Mill Road, Wheaton,		CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took care of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion					
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St.				DATE SIGNED 6/20/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-27-87		23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN SUITLAND		COUNTY	STATE
24. FUNERAL DIRECTOR NAME		ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 29 1987		25b. REGISTRAR'S SIGNATURE <i>June L. Johnson</i>	
WASHINGTON, D.C. 20019									

CHAPTER 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove additional pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If Item 21 is marked or left blank, any physician or other individual executing this certificate must be a medical examiner.

1 - STATE REGISTRAR
781STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH21039
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Franklin B. Seville						July 10, 1987				2:30 AM	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian	MONTH	DAY	YEAR	78	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania		USA					Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park		805 Maplewood Avenue			Technician		Electronics				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Montgomery	Takoma Park			805 Maplewood Avenue 20912					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		LAST				
		Frank	P.	Seville	Lila		Hiles				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
no		176-05-4031			John B. Seville/son		same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		cardiorespiratory arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
							1 minute				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		DUE TO, OR AS A CONSEQUENCE OF (b) lung cancer					9 months				
		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 6/30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					Nov 12 86		July 10 87				
22b. SIGNATURE Barry A. Silver		DEGREE MD			ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/10/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry A. Silver MD		22e. ADDRESS 116 Irving St., NW, Washington, DC 20010									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
burial		July 11, 1987		Parklawn		Rockville		Montgomery		Maryland	
24. FUNERAL DIRECTOR NAME		Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
					JUL 16 1987						
DHMH - 16 60M 7/84 (VRA 15, 4)		500 University Blvd., W Silver Spring, MD 20901									

02882 1151 1151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filled in by the funeral director and sent with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, informed consent must be obtained from the physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21040		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
DONALD EUGENE SEYMOUR						JULY 22 1987			5:46 A			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 2 1919			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY					
13a. STATE MARYLAND		13b. COUNTY FREDERICK		13c. CITY OR TOWN FREDERICK			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 601 LEE PLACE 21701			
14. FATHER'S NAME FIRST LAWRENCE THOMAS SEYMOUR				15. MOTHER'S MAIDEN NAME ELIXABETH SARA MCCOLLUM								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1938-1958		17. INFORMANT HELEN SEYMOUR, P.O. BOX 1452, FREDERICK, MD 21701								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION JULY 21, 1987												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED STOMA RESECTION FOR DIVERTICULOSIS		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (we) (hospital) attended the deceased from JULY 16, 1987, to JULY 22, 1987, that (I) (we) last saw the deceased alive on JULY 22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Name) (did) (did not) view the body after death.												
22b. SIGNATURE Sara S. MD		22c. DEGREE		22d. DATE SIGN 23 July 87								
22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/24/87		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl. Cem.		23d. LOCATION CITY OR TOWN Arlington		COUNTY		STATE Arlington VA		
24. FUNERAL DIRECTOR NAME 1621 Opossumtown Pike, Frederick, MD 21701		25a. DATE REC'D. BY REGISTRAR AUG 3 1987		25b. REGISTRAR'S SIGNATURE Julia S. Johnson, R.R.C.								

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21041
REG. NO.

FOR
STATE
REGISTRAR

059615 JUL 16 1981
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DETAILS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 3. USE AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF MEDICAL EXAMINER, 21201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST Robert	MIDDLE L.	LAST Shanholtz	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH July	DAY 15	YEAR 1981
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 MRS. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD	MONTH July	DAY 15	YEAR 1981
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		USA				Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Md. Hospital		Holy Cross Hosp				Proprietor		Gas Station	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12208 Charles Rd	
Md.		Montgomery		Md.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ADDRESS Silver Spring, Md.	
14. FATHER'S NAME FIRST Martin		MIDDLE E.	LAST Shanholtz	15. MOTHER'S MAIDEN NAME FIRST Oleta		MIDDLE Pearl	LAST Arnold		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO 235-32-0354		17. INFORMANT Aerietta Shanholtz, 12208 Charles Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <i>Chronic Myocardial Dis. 4 yrs.</i> DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>									
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>[Signature]</i> M.D. <i>[Signature]</i> MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT)									
ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/16/87		23c. NAME OF CEMETERY OR CREMATORIUM Enon Cemetery		23d. LOCATION Largent, Morgan, WV		COUNTY STATE	
24. FUNERAL DIRECTOR NAME Heisley-Johnson F.H. <i>[Signature]</i>		25a. DATE JUL 15 1987		25b. BY REGISTRAR [Signature]		25b. REGISTRAR'S SIGNATURE [Signature]			
25c. DATE JUL 15 1987									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the funeral director. If removal is to be delayed, notify the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other unusual event, the medical examiner must be notified or once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21042			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
ALLEN LEONARD SHAPERO						JULY 20 1987			12:00 P				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
MALE		CAUCASIAN		MARCH 24 1927		60							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
PENNSYLVANIA		UNITED STATES						MONTGOMERY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		NAVAL HOSPITAL								U.S. NAVY		DEFENSE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		99999			
VIRGINIA		FAIRFAX		ALEXANDRIA				8208 TREEBROOK LANE		22308			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
		DAVID HERMAN SHAPERO						ESTHER HILDA BRODY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
YES		1944-1987		220-20-1090		LENORE E. SHAPERO, 8208 TREEBROOK LANE.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		ALEXANDRIA, VA 22308								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RESPIRATORY ARREST											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER											
{		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from JUNE 22, 1987, to JULY 20, 1987, that (I) (we) last saw the deceased alive on JULY 20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE R. P. Dolan MD		DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						22f. DATE SIGNED 21 July '87					
R. P. DOLAN, LT, MC, USNR		NAVAL HOSPITAL BETHESDA, MD 20814-5011											
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE			
Burial		7-23-87		Arlington National		Arlington				Va.			
24. FUNERAL DIRECTOR NAME		Marshall's Funeral Home, Inc. 4217 9th Street, N.W. Washington, D.C. 20011						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
								JUL 28 1987		R. P. Dolan			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN, IN ITEM 18, WITH FORM PM. 3. RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BALTIMORE, MARYLAND, 21201

BP _____
DMMH - 17
(VR A15 ME (5))STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH21045
REG. NO.

1- STATE REGISTRAR			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR	
DECEASED NAME (TYPE OR PRINT)			MIDDLE			<input checked="" type="checkbox"/>	07	22	1987	2214	
Mildred			NMN			Sharp					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN						
female	black	02 03 05	82 yrs.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.			U. S. A.					Montgomery County MD			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma PARK			Washington Adventist Hospital			hospital					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	
Maryland			PG			Lewisdale				7006 22nd Place 20783	
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST		
Uriel Sharp									Caroline		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
(If Yes, give war or dates)			214 07 8815						7006 22nd Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Carcinoma of Rectum</u> DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (o) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>											
19a. DATE OF OPERATION <u>None</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Spence D. B. P.</u>											
EXAMINER'S NAME (TYPE OR PRINT)											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 7/25/87			23c. NAME OF CEMETERY OR CREMATORIAL Parsons Chapel			23d. LOCATION CITY OR TOWN Cottage		
24. FUNERAL DIRECTOR NAME Stewart Funeral Home Cambridge Md.			ADDRESS						25a. DATE REC'D. BY REGISTRAR AUG 05 1987	25b. REGISTRAR'S SIGNATURE Julia T. ...	

165-204 #10100

05987-2 JUL 7 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other truimote

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Lianna Janelle Shaw						July 12, 1987			1157 AM		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 12, 1987			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 1 30		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Silver Silver		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/a		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. STATE -----		13b. COUNTY -----		13c. CITY OR TOWN Washington DC			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE POBox 59273 99999 20012		
14. FATHER'S NAME FIRST Michael		MIDDLE Laneal		LAST Wilson			15. MOTHER'S MAIDEN NAME FIRST Bernice		MIDDLE LAST Shaw		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Holy Cross Hospital Department of Social Services, Silver Spring, Md.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extreme Prematurity											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>C Taubman MD</i>										DEGREE	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C Taubman MD</i>		22e. ADDRESS 50 W Edmonston Dr Rockville Md								22f. DATE SIGNED 7/13/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/15/87		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria, Va.		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME 1331 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR JUL 16 1987								25b. REGISTRAR'S SIGNATURE <i>Julia Sander-Landale</i>	

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(VRA 15, 4)

1651 JL 8-58.020

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	80337	80338	80339	80340	80341	80342	80343	80344	80345	80346	80347	80348	80349	80350	80351	80352	80353	80354	80355	80356	80357	80358	80359	80360	80361	80362	80363	80364	80365	80366	80367	80368	80369	80370	80371	80372	80373	80374	80375	80376	80377	80378	80379	80380	80381	80382	80383	80384	80385	80386	80387	80388	80389	80390	80391	80392	80393	80394	80395	80396	80397	80398	80399	80400	80401	80402	80403	80404	80405	80406	80407	80408	80409	80410	80411	80412	80413	80414	80415	80416	80417	80418	80419	80420	80421	80422	80423	80424	80425	80426	80427	80428	80429	80430	80431	80432	80433	80434	80435	80436	80437	80438	80439	80440	80441	80442	80443	80444	80445	80446	80447	80448	80449	80450	80451	80452	80453	80454	80455	80456	80457	80458	80459	80460	80461	80462	80463	80464	80465	80466	80467	80468	80469	80470	80471	80472	80473	80474	80475	80476	80477	80478	80479	80480	80481	80482	80483	80484	80485	80486	80487	80488	80489	80490	80491	80492	80493	80494	80495	80496	80497	80498	80499	80500	80501	80502	80503	80504	80505	80506	80507	80508	80509	80510	80511	80512	80513	80514	80515	80516	80517	80518	80519	80520	80521	80522	80523	80524	80525	80526	80527	80528	80529	80530	80531	80532	80533	80534	80535	80536	80537	80538	80539	80540	80541	80542	80543	80544	80545	80546	80547	80548	80549	80550	80551	80552	80553	80554	80555	80556	80557	80558	80559	80560	80561	80562	80563	80564	80565	80566	80567	80568	80569	80570	80571	80572	80573	80574	80575	80576	80577	80578	80579	80580	80581	80582	80583	80584	80585	80586	80587	80588	80589	80590	80591	80592	80593	80594	80595	80596	80597	80598	80599	80600	80601	80602	80603	80604	

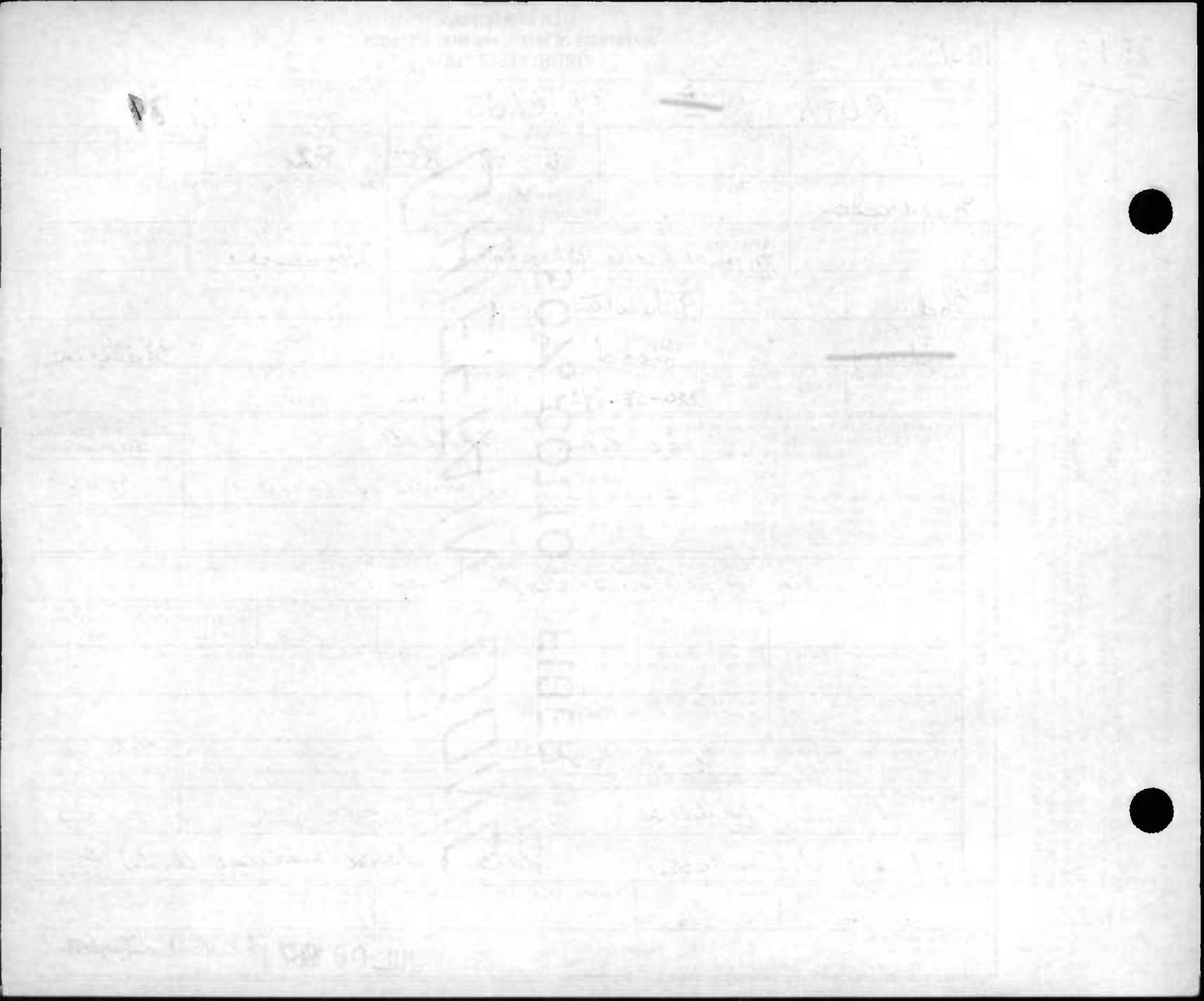
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 1, thru item 15 Film G630 8/27/87
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
11- STATE
REGISTRAR21045
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Ruth		LAST Elizabeth		20. DATE OF DEATH MONTH DAY YEAR		26 HOUR M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH 6 DAY 26 YEAR 85		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS YRS.	
7a. BIRTHPLACE COUNTRY Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		12b. KIND OF BUSINESS OR INDUSTRY Housewife	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Wheaton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 00000	
13a. STATE Md.		13b. COUNTY Montgomery		13d. CITY OR TOWN Wheaton		15. MOTHER'S MAIDEN NAME Sadie Jane		LAST Watkins	
14. FATHER'S NAME First William Henry Harry		LAST Wood		16b. SOCIAL SECURITY NO. 220-58-7428		17. INFORMANT MANOR CARE NURSING HOME		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hypertension</i> <i>Anger w/o sclerosis.</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i> <i>Anger w/o sclerosis.</i></p>									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Al Dementia of Alzheimer type Severe.</i></p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
<p>22a. I certify that (I) (we) attended the deceased from <i>1983</i>, 19, to <i>1987</i>, 19, that (I) (we) lost saw the deceased alive on <i>6. 20 87</i>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <i>Oliver J. Lawless</i>		22c. DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 7.7.87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>OLIVER J. LAWLESS</i>		22e. ADDRESS Leisure World Medical Center Silver Spring							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 7-7-87		23c. NAME OF CEMETERY OR CREMATORIAL STATE ANATOMY BOARD		23d. LOCATION CITY OR TOWN		COUNTY STATE	
24. FUNERAL DIRECTOR NAME STATE ANATOMY BOARD		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 08 1987		25b. REGISTRAR'S SIGNATURE <i>Julie Anderson Pendell</i>			



The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

HOSPITAL OR ATTENDING PHYSICIAN. The

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the hospital or attending physician.

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MEDICAL CERTIFICATION

887 FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21340
REG. NO.

1885 JUL 20 80 00

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BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician and completely filled in by the funeral director. Page 1 and 2 should be kept with the funeral director. Page 3 should be given to the medical examiner if the death is sudden, unexpected, or unusual.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-trust permit. Turn page 3 to remove carbon paper. Pages 1 and 2 should be kept with the funeral director. Page 4 may be signed by the funeral director. Page 3 should be given to the medical examiner if the death is sudden, unexpected, or unusual.

IMPORTANT: If Item 21 is marked or Item 18 shows any indication of a criminal or traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			8. REG. NO. 21947						
2. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
STEVEN HAROLD SINGER						JULY 31, 1987 4:00p M			
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR MARCH 9, 1946		6. AGE (IN YEARS LAST BIRTHDAY) 41 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Illinois		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreign Service O		12b. KIND OF BUSINESS OR INDUSTRY State Dept.			
13a. STATE N/A		13b. COUNTY N/A		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4707 CONNECTICUT AVENUE / 20008	
14. FATHER'S NAME FIRST Sidney		MIDDLE Singer		LAST Marian		15. MOTHER'S MAIDEN NAME FIRST Pinsker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 560-60-9749		17. INFORMANT (Wife) Elizabeth Ann Peterson		ADDRESS Same as #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF LYMPHOMA (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. DUE TO, OR AS A CONSEQUENCE OF LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 30, 1981, to JULY 31, 1987, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JULY 31, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE Louis Vassilios, M.D.		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Vassilios, M.D.		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892		22f. DATE SIGNED 8/1/1987					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transfer		23b. DATE August 1987		23c. NAME OF CEMETERY OR CREMATORIAL Hillside Memorial Park Los Angeles		23d. LOCATION CITY OR TOWN Los Angeles		STATE California	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 06 1987		25b. REGISTRAR'S SIGNATURE Yvonne L. Rader					

188-304 210500
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			7a. DATE OF DEATH MONTH DAY YEAR		
NORA V SINNETT									July 31, 1987		
3. SEX Female			4 RACE Cauc.			5. DATE OF BIRTH MONTH DAY YEAR Jan. 13, 1893			6. AGE (IN YEARS (LAST BIRTHDAY)) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 94 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH GAIITHERSBURG			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8709 DEANNA DRIVE			12a. USUAL OCCUPATION (TYPE OF WORK OR PART OF WORKING LIFE) NURSE			12b. KIND OF BUSINESS OR INDUSTRY NURSING HOSPITAL		
13a. STATE MD.			13b. COUNTY MONT.			13c. CITY OR TOWN GAIITHERSBURG			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME JOHN ST			MIDDLE WESTROPE LAST			15. MOTHER'S MAIDEN NAME UNKNOWN			16. ADDRESS UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 370-32-4750			17. INFORMANT MARIE O'BRIEN SAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <i>Varicose Cardiomyopathy + CCF</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>> 10 yrs</i> DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>HBP, AR, CVA, PVC</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 19 81</i> to <i>7/31 1987</i> , that (I) (we) last saw the deceased alive on <i>6/3 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>D. Friedman</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>7/31/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dennis Friedman</i>			22e. ADDRESS <i>15225 Shady Grove Rd, Rockville</i>								
23a. BURIAL, CREMATION, REMOVAL (S) BURIAL			23b. DATE Aug. 1, 1987			23c. NAME OF CEMETERY OR CREMATORIUM ST. JOSEPH CEMETERY			23d. LOCATION CITY OR TOWN KINGSBRIDGE HURON ONTARIO COUNTY		
24. FUNERAL DIRECTOR MURIEL H. BARBER			ADDRESS LAYTONSVILLE, MD. 20879			25a. DATE REC'D. BY REGISTRAR <i>AUG 04 1987</i>			25b. REGISTRAR SIGNATURE <i>BP</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the document be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / REG. NO. 21049

1. DECEASED NAME (TYPE OR PRINT)			NATHAN SINNREICH			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 09:25AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 3, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) ROMANIA		7b. CITIZEN OF WHAT COUNTRY? ROMANIAN		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST		12a. USUAL OCCUPATION ENGINEER			12b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13b. COUNTY MONT 13c. CITY OR TOWN GAITHERSBURG						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4 WATCH HILL PLACE 20878	
14. FATHER'S NAME CHAIM		MIDDLE SINNREICH		15. MOTHER'S MAIDEN NAME FRITZ			MIDDLE EISENSTEIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO NO OR UNKNOWN		16b. SOCIAL SECURITY NO. 213-02-8681		17. INFORMANT HENRY SINNREICH, ADDRESS 4 WATCH HILL PLACE GAITHERSBURG, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Failure, Pulmonary</i>				
						DUE TO, OR AS A CONSEQUENCE OF (c) <i>Inefficiency - Pump Failure</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
19a. DATE OF OPERATION 6/29/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>7/15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE <i>Samir Neimai</i>			22c. DATE SIGNED 7/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMIR NEIMAI, M.D.						22e. ADDRESS 10313 GEORGIA AV. SILVER SPRING, MD, 20902				
23a. BURIAL, CREMATION, REMOVAL SPECIAL BURIAL		23b. DATE 7/19/1987		23c. NAME OF CEMETERY OR CREMATORIAL JUDEAN MEMORIAL GARDENS		23d. LOCATION OLNEY, MONTGOMERY, MARYLAND				
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE RECEIVED BY RELEASER JUL 24 1987			25b. RELEASED Signature	

080831 JUL 28 83

061354 JUL 30 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please attach this page to the death certificate and mail with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical certification section should be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																					
8 / 1 0 5 0 REG. NO.																					
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR							
Dorothy M. Sirk									7 28 87					3:20AM							
3. SEX		FEMALE		4. RACE			WHITE		5. DATE OF BIRTH		YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
									FEB TH 24, 1929					58		MONTHS		DAYS		HOURS	
7c. BIRTHPLACE (STATE OR FOREIGN)		MD ^{TRY}		7b. CITIZEN OF WHAT COUNTRY?			USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
														Montgomery		MD					
10. CITY OR TOWN OF DEATH		Olney			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF SUCH FACILITY, GIVE STREET ADDRESS)			Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		H. Maker			12b. KIND OF BUSINESS OR INDUSTRY		Home			
13a. STATE		Md.		13b. COUNTY		Montgomery		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS		ZIP CODE			24250 Hipsley Mill Rd.		20879				
14. FATHER'S NAME		URIAH ^{1ST}		MIDDLE		PEUGH ^{2ND}		15. MOTHER'S MAIDEN NAME		LUCY ^{1ST}		* MIDDLE		WARFIELD ^{2ND}		LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		NO		16b. SOCIAL SECURITY NO.		212-22-0303		17. INFORMANT		JOSEPH F. SIRK, SR.		ADDRESS		SAME AS # 13							
18. CAUSE OF DEATH (Enter only one cause per line for item 18, 19, and 20.) PART 1. DEATH WAS CAUSED BY.		Circumstances of death										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
		IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										5 minutes									
		DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Pancreatic Carcinoma										4 months									
		DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) <input type="checkbox"/> the hospital attended the deceased from <u>July 27</u> , 1987, to <u>July 28</u> , 1987, that (I) <input type="checkbox"/> lost saw the deceased alive on <u>July 27</u> , 1987, and that in (my) <input type="checkbox"/> ^{loss} _{loss} opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.																					
22b. SIGNATURE Jules R. Lodish		DEGREE M. D.										22c. DATE SIGNED 7/28/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jules R. Lodish		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE JULY 30, 1987		23c. NAME OF CEMETERY OR CREMATORIAL MT. TABOR		23d. LOCATION ETCHISON		CITY OR TOWN MONT.		COUNTY		STATE MD.									
24. FUNERAL DIRECTOR MURIEL H. BARBER		NAME LAYTONSVILLE, MD. 20879		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 30 1987		25b. REGISTRAR'S SIGNATURE Muriel H. Barber													

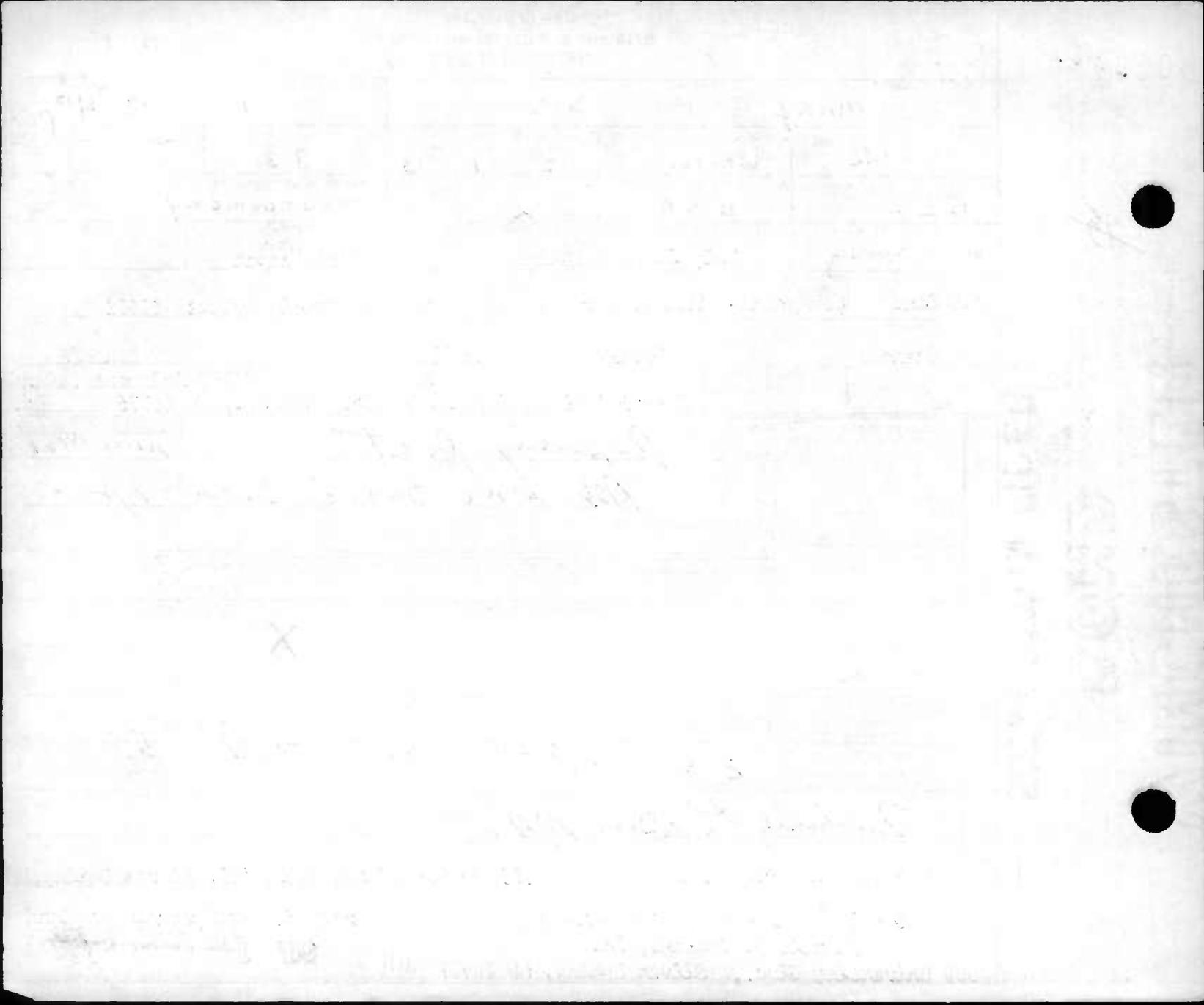
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed in by the funeral director, page 3 should be detached for use as the burial/transit permit when you remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any history of other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 21051		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
MARY F Sis						12	31	YEAR	7	1	87	4:15 P.M.		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female			White		MONTH	DAY	YEAR	73	YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery					
D.C.			U.S.A.						MD.					
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 24 Darwin Avenue 20912						
14. FATHER'S NAME FIRST Carmelo			MIDDLE Furnari			15. MOTHER'S MAIDEN NAME FIRST Aufina			MIDDLE LAST Consoli					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no 577-10-7948			17. INFORMANT son John A. Sis, Jr.			ADDRESS 4197 Solomons Island Rd. Harwood, MD 20776			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unnoted		
18. CAUSE OF DEATH (Enter only one cause per line for Part 1a, and if applicable, Part 1b. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) <i>Pneumonia, Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Allergic Asthma, Gastric Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5-29-87 to 7-7-87, that (1) (we) last saw the deceased alive on 6-30-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Frederick G. Barr, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick G. Barr, M.D.			22e. ADDRESS 2101 Medical Park Drive #211 Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE July 6, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn			23d. LOCATION CITY OR TOWN Rockville			COUNTY Montgomery	STATE Maryland	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W Silver Spring, MD 20901						25a. DATE REC'D. BY REGISTRAR 11/11/87			25b. REGISTRAR'S SIGNATURE Julie S. Danaher					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

541 15 87

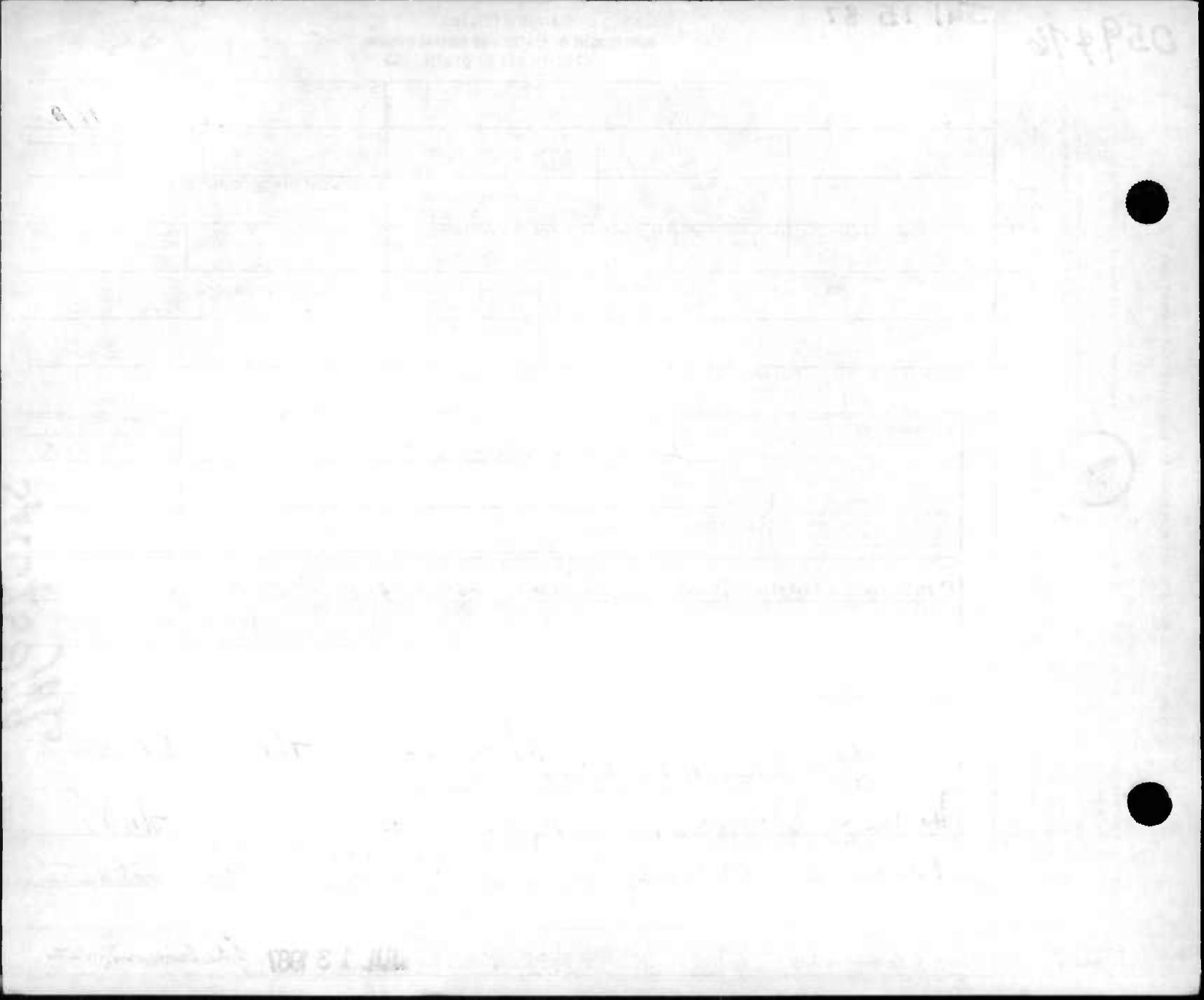
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21052

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Blanche A. Smith						July 10	1987			11 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
Female	White	Jan. 9, 1900			87	YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
England	USA				Montgomery					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton	Randolph Hills Nursing Home			Housewife			own home			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Virginia		Arlington			823 N. Harrison St., 22203					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
Jess			Burton	Blanche			Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
N/A	N/A 579-44-6704 D		Catherine S. Vogel-dau- (same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>912</u> <u>LOBAR PNEUMONIA</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u>				
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>CHRONIC ORGANIC BRAIN SYNDROME; RECURRENT ASPIRATION</u>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/9</u> 19 <u>87</u> , to <u>7/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>Martin C. Shargel</u>						DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/11/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Martin C. Shargel</u>						22e. ADDRESS 3720 FAIRFAX AVE. KENSINGTON, MD - 20895				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 7-14-1987	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION SUITLAND		23e. TOWN Pr. Georges		23f. MD.
24. FUNERAL DIRECTOR Hines' Rinaldi Funeral Home						25a. DATE REC'D. BY REGISTRAR 11800 N. H. Ave. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendell</u>		
						JUL 13 1987				

DMMH 16 60M 7/84
(VRA 16, 4)
BP
999999



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (autopsy) should be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21053

1. DECEASED NAME (TYPE OR PRINT) Glatha Jewel Smith				2a. DATE OF DEATH MONTH YEAR 7, 12, 87	2b. DAY 7	2c. MONTH JULY	2d. YEAR 1987	2e. HOUR IF UNDER 12 HRS. MONTHS DAYS 0600 0 0	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 8, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7. IF UNDER 24 HRS. HOURS MIN. 0 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? United States		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 581 West Diamond Avenue / 20877	
14. FATHER'S NAME FIRST Palmer		MIDDLE Smith		15. MOTHER'S MAIDEN NAME FIRST Ruby		LAST Pulley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) 428-52-1349		17. INFORMANT Catherine H. Leta,		ADDRESS 124 Deer Park Way Gaithersburg, MD 20877			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, fulminant DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic bronchogenic carcinoma, January 1987 DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Deceased from					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (We) attended the deceased from January 1987 to 7/12, 1987 , that (I) (We) last saw the deceased alive on 7/12, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
22b. SIGNATURE John G. Losmell, MD.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/12/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Losmell, MD.		22e. ADDRESS 2901 Chevy Chase Rd. Chevy Chase, MD 20815							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-15-87		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Albuquerque, New Mexico		COUNTY	STATE
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc.		ADDRESS P. O. Box 43352, Washington, DC 20010		25. DATE REC'D. BY REGISTRAR JUL 13 1987		26. REGISTRAR'S SIGNATURE J. Oliver, MD			

RECORDED BY
THE FBI
1968

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

2. REG. NO. 2.054

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO EFINAL CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)	LAST			2a. DATE KNOWN OF DEATH MATED	2b. MONTH YEAR
John Smith				July 20 1987	10 1987
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS.
M	BLK	1 24 1900	87		
7b. BIRTHPLACE CITY, STATE AND ZIP CODE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Wash. D.C.		U.S.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Tke Park		Washington Hosp. Corp		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE 13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		Prince George's Hyattsville		13e. STREET ADDRESS 6905 Ridge Rd. Hyattsville, Md.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.	
Eugene Smith		MATTIE REED		578-01-9294 Joseph L. Smith	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. INFORMANT		ADDRESS 5805 Ridge Rd. Hyattsville, Md.	
NO		578-01-9294 Joseph L. Smith		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Double Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.					
(b) <u></u> DUE TO, OR AS A CONSEQUENCE OF					
(c) <u></u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>					
19a. DATE OF OPERATION <u>None</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Smith</u> M.D., <u>John Smith</u> MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT)					
TITLE (SPECIFY) ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <u>7/25/87</u>	23c. NAME OF CEMETERY OR CREMATORIAL HARMONY MEMORIAL PARK		23d. LOCATION CITY OR TOWN Lanodover, Md.	
24. FUNERAL DIRECTOR NAME <u>Hall Bros. Funeral Home</u>	ADDRESS <u>621 E. 20th Ave. N.W.</u>	25. DATE REC'D. BY REGISTRAR <u>JUL 23 1987</u>		25. REGISTRAR'S SIGNATURE <u>Julia F. Johnson-Lindner</u>	

060818 JUL 29 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

signed by the attending physician and completely filled in by the funeral director. Page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then placed in a mortuary carbon paper, Pages 1 and 2 should be detached for use as the burial/transit permit. Then place in Burial Certificate, or removed with the State Dept. of Health and Mental Hygiene prior to Burial. Certification or removal of this certificate is required by law.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 21055			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
MARSHALL E. Smith						07-30-87 5 PM			26 HOUR						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
MALE		BLACK		Dec. 9, 1919			67			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Caddy					
Md.		USA													
11. CITY OR TOWN OF DEATH Bethesda		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Suburban		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 611 Edgewood Ter. 20017 21 N.E.			12b. KIND OF BUSINESS Industry					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN WASH. D.C.											
14. FATHER'S NAME Greenberry Smith		15. MOTHER'S M AIDEN NAME Rachael Pratt													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.		16b. SOCIAL SECURITY NO. WWII 214-16-7337		17. INFORMANT Blanche Jackson (sister)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH same as #15								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the Esophagus</i> DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from 7-1, 1987, to 7-30, 1987, that (I) (we) lost saw the deceased alive on 7-30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>John Tamber</i>		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 8-30-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tamber															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-5-87			23c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial Cem.			23d. LOCATION CITY OR TOWN Sandy Spring, Montg.			COUNTY MD.				
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS Rockville, MD 20850			25a. DATE REG'D. BY REG. STAFF AUG 05 1987			25b. REGISTRAR'S SIGNATURE <i>George R. Snowden</i>							

06/15/14 10:08

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial Permit. This places the certificate in carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other domestic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 21056	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
OPAL LOUISE SMITH						JULY 14, 1987					7:57 p.m.
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 24, 1921		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE W. VIRGINIA		13b. COUNTY Fayette		13c. CITY OR TOWN DANESE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. 1, BOX 97 25831 99999			
14. FATHER'S NAME FIRST CLARENCE		MIDDLE A.		LAST SWEET		15. MOTHER'S MAIDEN NAME FIRST LYDIA		MIDDLE E.		LAST McCoy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-64-9530		17. INFORMANT Bertha Hanshew (daughter) Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST											
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS											
DUE TO, OR AS A CONSEQUENCE OF (c) OVARIAN CARCINOMA											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 22, 1987, to JULY 14, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 14, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <i>John Vandemoer, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Vandemoer, M.D.		22e. ADDRESS NIH, (NATIONAL INSTITUTES OF HEALTH) 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 18 July 87		23c. NAME OF CEMETERY OR CREMATORIAL Wallace Mausoleum		23d. LOCATION CITY OR TOWN Greenbriar County, W. Va.					
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 17 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Lindsey					

2805 JUL 5 1982

10000 V. sec

sec

sec

10000 (various) volt sec

V. sec 10000 volt sec

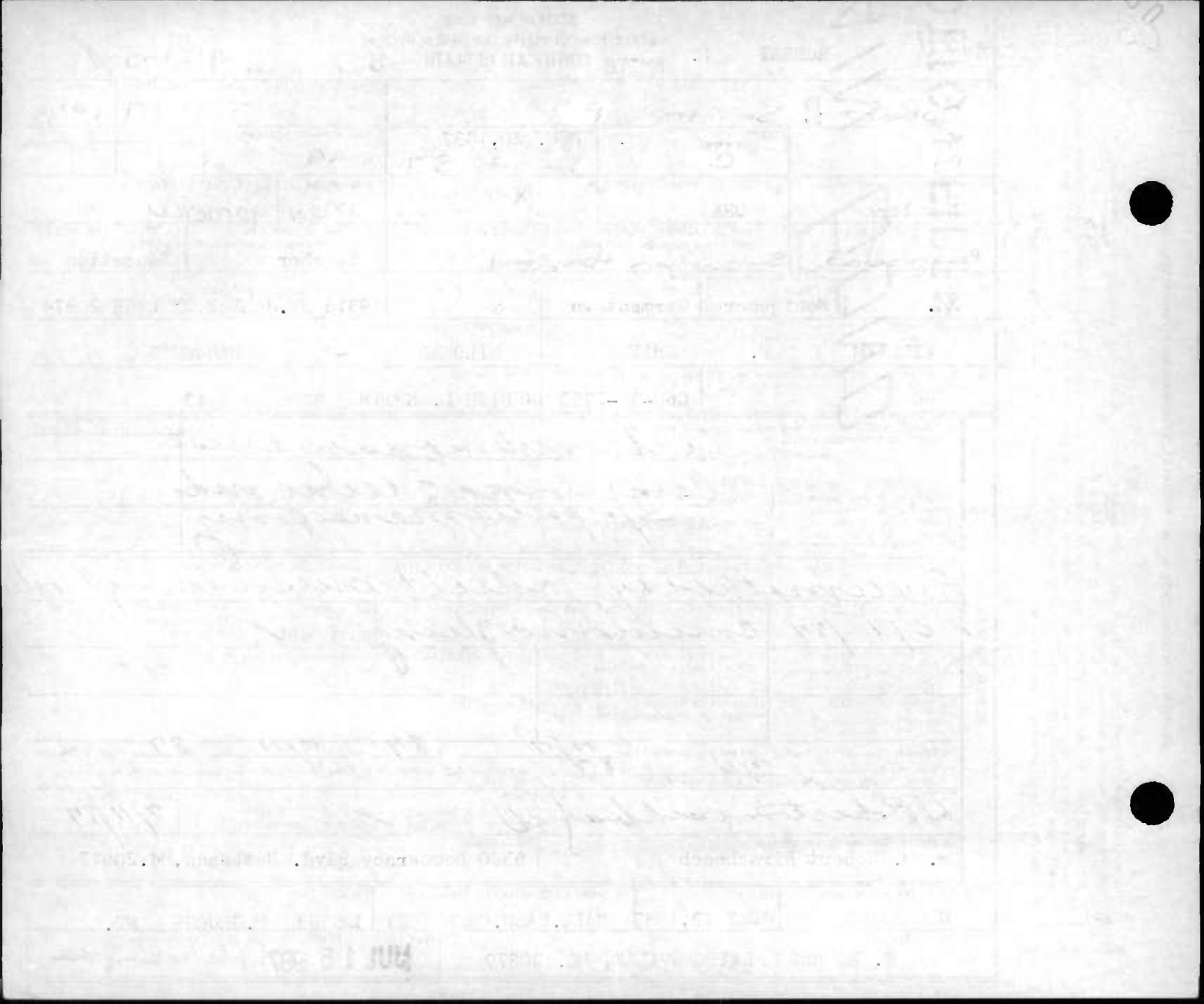
V. sec 10000 volt sec

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's office. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE SMITH CERTIFICATE OF DEATH												REG. NO. 87	2 JULY 05 1														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR															
Robert P. Smith						5 DECEMBER 20, 1987			MONTH	DAY	YEAR	7 11 87 104 PM															
3. SEX MALE			4. RACE WHITE			12 20 37			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			10a. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher				12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Germantown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 19316 ST, JOHNSBURY LANE 20874															
14. FATHER'S NAME FIRST WILLIAM			MIDDLE F.			LAST SMITH			15. MOTHER'S MAIDEN NAME FIRST MILDRED			MIDDLE -			LAST MAGNUSON												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. ADDRESS			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE PISTOL AS TIME OF ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																											
19a. DATE OF OPERATION 6/1/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma, lung			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Pneumothorax, adult muscular dystrophy															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7/11/87 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) (did not) view the body after death.			22b. SIGNATURE Dr. H. Robert Birschbach			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 7/11/87															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE JULY 13, 1987			23c. NAME OF CEMETERY OR CREMATORIAL BALT. WASH. CREMATORIAL			23d. LOCATION CITY OR TOWN LAUREL			23e. ADDRESS 6320 Democracy Blvd. Bethesda, Md. 20817		P. GEORGE MD.													
24. FUNERAL DIRECTOR MURIEL H. BARBER			25a. DATE REC'D. BY REGISTRAR JUL 15 1987			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pardelle																					



060837

JUL 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH21058
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR				2b. HOUR					
Russell F Smith						7	17	1987							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
MALE		CAUCASIAN		10	10	1937	49								
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.					
MARYLAND		U.S.A.				MONTGOMERY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
GAITHERSBURG		363 W. SIDE DR. #101				TRUCK DRIVER									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		863 W. SIDE DRIVE #101 - GAITHERSBURG, MD 20878					
MD		MONTG		GAITHERSBURG											
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		NICKOLS					
LEE		FRANKLIN		SHUTT		BEULAH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
UNKNOWN		220-32-5177		ELSIE MALONE		14601 W. OLD BALTIMORE BOYDS, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiovascular accident</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>high lipids</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>severe esophagitis</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 19 85</u> to <u>June 21 1986</u> , that (I) (we) last saw the deceased alive on <u>June 12 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Mary H. Farn, M.D.</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/17/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Mary H. Farn, M.D.</u>		22e. ADDRESS <u>50 w. Edmonston Dr Rockville, Md</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>7-20-87</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>MONOCACY</u>		23d. LOCATION CITY OR TOWN <u>BEAVERVILLE</u>		COUNTY <u>MONTG</u>		STATE <u>MD</u>					
24. FUNERAL DIRECTOR NAME <u>W. C. HILTON</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 22 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Dawson-Lindner</u>											

1985 JUL 18 8020

1985 JUL 18 8020

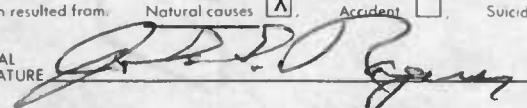
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. FORM 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

MEDICAL CERTIFICATION

1- STATE REGISTRAR
FOR
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21059

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2c. DATE KNOWN OF DEATH ESTIMATED MATERIAL	2d. DATE PRONOUNCED DEAD	2e. HOUR MONTH DAY YEAR	2f. HOUR MONTH DAY YEAR
Dora		Sosnik		7/14 19 87		7/14 19 87 3:38 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9. DATE PRONOUNCED DEAD	10. DATE RECD. BY REGISTRAR	
Female	White	Mar. 30, 1900	87 yrs.			7/14 19 87	JUL 17 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Russia		U.S.A.		XX	NEVER MARRIED DIVORCED	Montgomery County		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring		1220 East-West Highway, #1410				Homemaker		Home
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES X NO		13e. STREET ADDRESS
Maryland		Montgomery		Silver Spring		1220 East-West Highway, #1410		20910
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE LAST
Abraham				Wishneb		Anna		Burko
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS, Chevy Chase, Md.		
NO		213-50-1924		Doris Oshinsky		Daughter; 3602 Fair Castle		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimer's disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery County, MD				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						
John S. Rogers, M.D.								
23a. BURIAL, CREMATION, REMOVAL (SPEC #)		23b. DATE 7/15/87		23c. NAME OF CEMETERY OR CREMATORIUM Beth Shalom Cong. Cemetery		23d. LOCATION CITY OR TOWN Capitol Heights, Maryland		
Burial		7/15/87		Beth Shalom Cong. Cemetery		Capitol Heights, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 17 1987						
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike, Rockville, Md. 20852		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

29941 14002



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be given to the funeral director. Then please remove carbon copies. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			REG. NO. 871050			2b. HOUR 07-12-87 7:30 AM		
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST								
RAYMOND B SPRING											
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2609 Parker Avenue 20902		12b. KIND OF BUSINESS Furn & Carpet Cleaner Employed MD.	
14. FATHER'S NAME FIRST Raymond MIDDLE Apollus LAST Spring				15. MOTHER'S MAIDEN NAME FIRST Eva MIDDLE LAST Burch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578-03-4115		17. INFORMANT Violet V. Spring/wife same as 13		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia											
DO TO, OR AS A CONSEQUENCE OF (c) metastatic prostatic Cancer.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Anemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 9, 1987, to July 12, 1987, that (I) (we) lost saw the deceased alive on July 11, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
27a. SIGNATURE Joe Kahan		27b. DEGREE MD		27c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		27d. DATE SIGNED 7-12-87					
27e. PHYSICIAN'S NAME (TYPE OR PRINT) Joe Kahan		27f. ADDRESS 6111 EXECUTIVE BLVD, ROCKVILLE MD 20852									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 15, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn		23d. LOCATION CITY OR TOWN Rockville		COUNTY Montgomery		STATE Maryland	
24. FUNERAL DIRECTOR NAME Francis J. Collins Jr. 500 University Blvd., W Silver Spring, MD 20901				25a. DATE REC'D. BY REGISTRAR JUL 20 1987		25b. REGISTRAR'S SIGNATURE John P. Smith					

100154 77150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove sections 1a and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO. 21061															
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2d. DATE OF DEATH MONTH DAY YEAR		2d. HOUR	
Anna			E.			Stahl						July 3, 1987		11:25A	
3. SEX		4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Female		Caucasian			August 2, 1901			85			YRS				
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.							
Pennsylvania		United States													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Rockville		Rockville Nursing Home						Payroll Clerk.			Railroad				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Florida		13b. COUNTY Palm Beach		13c. CITY OR TOWN Boca Raton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 30 South East 13th Street 133432							
14. FATHER'S NAME FIRST Gustav		MIDDLE		LAST Gorenflo		15. MOTHER'S MAIDEN NAME FIRST Emilie		MIDDLE		LAST Lichtenwalter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. -			17. INFORMANT Frank Gorenflo, Brother, 132 W. 23rd St, #311, Erie, Pennsylvania 16502		ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest															
DUE TO, OR AS A CONSEQUENCE OF (b) Stroke 5/11/87															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from March 20, 1987, to July 3, 1987, that (I) <input type="checkbox"/> lost saw the deceased alive on June 24, 1987, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.															
22b. SIGNATURE Frauke Westphal		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED July 3, 1987								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal, M.D.		22e. ADDRESS 809 Viers Mill Road Rockville, Maryland 20851													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b. DATE July 4, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Erie Cemetery			23d. LOCATION CITY OR TOWN Erie		COUNTY Pennsylvania					
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850					25a. DATE JUL 8 1987			25b. C.D. BY REGISTRAR Julia Scardon-Lindale		25b. REGISTRAR'S SIGNATURE					

BP
999999
DHM# 160M 7/84
(VRA 15, 4)

CO

334

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. U 6 2

FOR
1- STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

20 DATE KNOWN
OF DEATH MATED

MONTH

DAY

YEAR

2b HOUR

59408
14673
15033
15033
15033

Female

Elizabeth

L.

Stallsmith

7

7

19

87

M

3. SEX

4. RACE

Female

5. DATE OF BIRTH
MONTH DAY YEAR

Caucasian April 21, 1909

6. AGE (IN YEARS
LAST BIRTHDAY)

78 yrs.

IF UNDER 1 YR. IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

2c DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

2d HOUR

4:34
P.M.

7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

United States

8 MARRIED
WIDOWED

NEVER MARRIED
DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

10 CITY OR TOWN OF DEATH

Suburban Hospital

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS
TRY

13a. STATE

13b. COUNTY

Maryland

Montgomery

13c. CITY OR TOWN

Kensington

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS

3817 Calvert Place

20895

14. FATHER'S NAME

FIRST MIDDLE LAST

Charles T. Lohr

15. MOTHER'S MAIDEN NAME

MIDDLE

LAST

Elizabeth Bowen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

9911 East Bexhill Drive

No

215-38-3083

Jeffry B. Stallsmith Kensington, Md 20895

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Neck/Chest Injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to the immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY
HOUR XX MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

4:02 P.M. 7 7 1987

Driver of auto/auto collision

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

WHILE NOT WHILE
AT WORK AT WORK

Street

Everett & Conn. Ave.

Montgomery

MD

22a. I certify that I took charge of the remains described above, held an

Autopsy Inspection Inquiry and in my opinion

death resulted from:

Natural cause Accident Suicide Homicide Undetermined manner

22b. TITLE (SPECIFY)

ACTUAL
SIGNATURE

M.D.

Assistant

MEDICAL EXAMINER

DATE
SIGNED 7-8-87

EXAMINER'S NAME
(TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS 111 Penn St., Balto. Md. 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

July

11, 1987

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION
CITY OR TOWN

Bethesda

COUNTY STATE

Maryland

Burial

Mt. Zion Cemetery

24. FUNERAL DIRECTOR

Robert A. Pumphrey Funeral Home,

Bethesda-Chevy Chase, Md.

7557 Wisconsin Ave.

25a. DATE REC'D. BY REGISTRAR

JUL 13 1987

25b. REGISTRAR'S SIGNATURE



062032 AUG

8-87
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 / 31063
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
			RUTH	ELIZABETH	STANLEY	7/14/87				9:40 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
FEMALE		W		MONTH	DAY	YEAR	68							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Arkansas		USA					MONTGOMERY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
GAIITHERSBURG		9919 KILLARNEY LANE			Homemaker			None						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland		Montgomery	Gaithersburg				9916 Killarney Lane/20877							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS						
		Ollie		Palmer	Minnie			9916 Killarney Lane Apt. 103						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Gaithersburg, Md. 20877							
NO		309 562158		Gus Stanley, Sr.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		LUNG CANCER												
		DUE TO, OR AS A CONSEQUENCE OF (b) CIGARETTEsmoke												
		DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE
22a. I certify that (I) (the physician) attended the deceased from 5/15/87 to 7/14/87, that (I) (we) last saw the deceased alive on 7/2/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.														
22b. SIGNATURE Alan S. Chanales		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/14/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
Alan Chanales, M.D.		15225 Shady Grove Road Rockville, Md. 20850												
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 7-17-1987		23c. NAME OF CEMETERY OR CREMATORIAL Brookside Cemetery			23d. LOCATION CITY OR TOWN Houston, Harris, Texas			COUNTY				STATE
24. FUNERAL DIRECTOR R.E. DAILEY & SON, PA		ADDRESS 1201 N. Market Street Frederick, Md. 21701			25a. DATE REC'D. BY REG. OF MARYLAND JUL 31 1987			25b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then attach to the burial/transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, air other traumatic event, no medical certification should be furnished or done.

061503Z AUG-88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove this paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#30 Perfh 7/13/87 km
1 - STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21064

1. DECEASED NAME (TYPE OR PRINT) Hillary Walters W. St. Clair				2a. DATE OF DEATH MONTH DAY YEAR July 14, 1909	2b. HOUR 855 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 14, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 77	7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Utah	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Metallurgist US Gov't.	
13a. STATE MD	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6917 Racehorse Lane/20852	
14. FATHER'S NAME FIRST Edwin	MIDDLE ---	LAST St. Clair	15. MOTHER'S MAIDEN NAME FIRST Mary	MIDDLE Pearl	LAST Walters
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. ---	17. INFORMANT Carmen C. St. Clair, Same address as #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE WEEK		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ESOPHAGOENTEROSTOMY DEHISCENCE			ONE WEEK		
DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGOENTEROSTOMY DEHISCENCE			STAGE 6 MONTHS		
DUE TO, OR AS A CONSEQUENCE OF (c) GASTRIC / ABDOMINAL LARGE CELL LYMPHOMA - II A E					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION 6/23/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTRIC LYMPHOMA - PERFORATION			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) RECORDED			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from MAY , 19 87 , to JULY , 19 87 , that (1) (we) last saw the deceased alive on 7/2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alan N. Schulman, M.D.	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/13/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN N. SCHULMAN, M.D.	22e. ADDRESS 9715 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/7/87	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park	23d. LOCATION CITY OR TOWN Rockville, MD	COUNTY	STATE
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.	ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C.	25a. DATE REC'D. BY REGISTRAR JUL 7 1987	25b. REGISTRAR'S SIGNATURE Julia Sander Radale		

efficiency coefficient 0.50

061272 JUL 30 87
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
 REGISTRAR UNKNOWN #87-77

REG. NO. 20065

1. DECEASED NAME
 (TYPE OR PRINT)

FIRST

MIDDLE

LAST

20. DATE KNOWN
 OF ESTI-
 DEATH MATED

MONTH

DAY

YEAR

2D HOUR

Devon

Anthony

Steer

7/ 25/19 87

M

3. SEX

Male

4. RACE

5. DATE OF BIRTH

MONTH

DAY

YEAR

6. AGE (IN YEARS
 LAST BIRTHDAY)

23

YRS

IF UNDER 1 YR.

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

2c. DATE
 PRONOUNCED
 DEAD

MONTH

DAY

YEAR

2d. HOUR

7/ 25/19 87

M

7a. BIRTHPLACE (STATE OR
 FOREIGN COUNTRY)

Kingston, Jamaica

7b. CITIZEN OF WHAT COUNTRY?

Jamaica, W.I.

MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County,

MD

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
 (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
 FOR MOST OF WORKING LIFE)

Florist Assist.

12b. KIND OF BUSINESS
 OR INDUSTRY

9991
 Bronx N.Y.

13a. STATE

N.Y.

13b. COUNTY

Bronx

13c. CITY OR TOWN

Bronx

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS

1056 E. 226th St.

th

Bronx N.Y.

14. FATHER'S NAME

FIRST

Godfrey

MIDDLE

LAST

Steer

15. MOTHER'S MAIDEN NAME

FIRST

Yvonne

MIDDLE

LAST

Walters

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
 (YES, NO, OR UNKNOWN)
 (IF YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Godfrey Steer 817 E. 215th St. N.Y.

APPROXIMATE INTERVAL
 BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
 gave rise to immediate
 cause (a) stating the under-
 lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

UNDERLYING OR
 CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

? XX 7/ 25/ 87 subject shot

22d. INJURY OCCURRED

WHILE NOT WHILE
 AT WORK

21e. PLACE OF INJURY (AT HOME,
 STREET, FACTORY, FARM, ETC.)

on street

21f. LOCATION

STREET

CITY OR TOWN

13300 Blk. Holdridge Rd., Silver Sp., Montg., Md

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion

death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
 SIGNATURE

Margarita A. Korell, M.D.

TITLE (SPECIFY)
 M.D.

Assistant

MEDICAL EXAMINER

DATE
 SIGNED 7/25/87

EXAMINER'S NAME
 (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
 (SPECIFY)

Burial

23b. DATE

23c. NAME OF CEMETERY OR CREMATORI

Mt. Hope Cemetery

23d. LOCATION
 CITY OR TOWN

Hastings on Hudson, N.Y.

COUNTY

STATE

24. FUNERAL DIRECTOR

William C. Brown

ADDRESS

1206 W. North Ave. Balto., Md.

25a. DATE REC'D. BY REGISTRAR

JUL 29 1987

25b. REGISTRAR'S SIGNATURE

Julia Sander-Landau

081515 JUL 30 1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
8 1 2 1 0 0 0											REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Harry E STITES									STITES			7-30-87				7 A			
3. SEX male			4. RACE white			5. DATE OF BIRTH 7 16 05			6. AGE (IN YEARS LAST BIRTHDAY) 82			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		HOURS		MIN	
7a BIRTHPLACE Pennsylvania			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.										
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b KIND OF BUSINESS OR INDUSTRY Hwy Drafting										
13a STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Silver Spring			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 10921 Inwood Avenue 20902							
14. FATHER'S NAME George			15. MOTHER'S MAIDEN NAME Stites			16. SOCIAL SECURITY NO. 167-16-0670			17. INFORMANT niece Dorothy Stites			ADDRESS 1716 Merrimac Dr. Adelphi, MD 20783							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b) sepsis			20. DUE TO, OR AS A CONSEQUENCE OF (c) diabetes						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate							
												1 day							
												long standing							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
21a DATE OF OPERATION			21b CONDITION FOR WHICH OPERATION WAS PERFORMED			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21 OR PART 2)			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
21g. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)																
22a I certify that (I) this hospital attended the deceased from Aug 19 85 to Jul 30 1987, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death.												22c DATE SIGNED 7-30-87							
22b. SIGNATURE Ira Paul Kretting			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira Paul Kretting			22e. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 4, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Lawnview Cemetery			23d. LOCATION CITY OR TOWN Philadelphia		COUNTY		STATE Philadelphia MD						
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. W Silver Spring, MD 20901			25a. DATE REC'D. BY REGISTRAR AUG 03 1987			25b. REGISTRAR'S SIGNATURE Julia Sanderson-Randall													

061102 VME-# 85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8721061											
1- STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR		
Michael A. Stittgen						7-8-87			2b. HOUR 12 30 P.M.		
3 SEX Male			4 RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		
						9-30-59			7 yrs		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION Computer Operator			12b. KIND OF BUSINESS OR INDUSTRY Sovran Bank		
13a. STATE Maryland			13b. COUNTY Prince Georges			13c. CITY OR TOWN Adelphi			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
									13e. STREET ADDRESS / ZIP CODE 7911 24th Avenue 20783		
14. FATHER'S NAME FIRST Edward			MIDDLE John			LAST Stittgen			15. MOTHER'S MAIDEN NAME Lois Mae Moore		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 341-58-5919			17. INFORMANT mother Lois M. Stittgen			ADDRESS 1840 Apache Rd. Waukegan, IL 60087		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) PANCYTOPENIA + ANEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ACQUIRED Immunodeficiency Syndrome 7 days 7 months											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 BURKITT'S Lymphoma + CNS Lymphoma											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19, to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE EVERARD H. HUGHES			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 7/18/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVERARD H. HUGHES			22e. ADDRESS 8300 Corporate Dr. Landover MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE July 13, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Warren Cemetery			23d. LOCATION CITY OR TOWN Gurnee Lake		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR JUL 14 1987			25b. REGISTRAR'S SIGNATURE Julia Stittgen, D. L. S.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene and the medical examiner.

IMPORTANT: If item 21 is marked on Item 18, show any injury, or other traumatic event, in medical certification.

061060 JUL 29 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 21068

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Scott			Joseph	Stockstill		July	22	1987	12:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male	Caucasian	07 13 62	25	MONTHS	YEARS	HOURS	MIN.			
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington, DC	United States		Montgomery Co. MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda	Suburban Hosp.	Service Repres.	C&P Telephone							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME						
Maryland	Prince Geo.	Beltsville	Joseph	Dorothy L. Vermillion						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No	213-88-2460	Dorothy Stockstill (mother) Same as #13	Pneumocystis carinii pneumonia							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						DUE TO, OR AS A CONSEQUENCE OF (b) acquired Immune Deficiency DUE TO, OR AS A CONSEQUENCE OF (c) Sjogren's				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (he/she) attended the deceased from 6-24, 1987, to 7-22, 1987, that (I) (he/she) last saw the deceased alive on 7-22, 1987, and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated above, (I) (he/she) did (did not) view the body after death										22c. DATE SIGNED 7-22-87
22b. SIGNATURE John Tauber		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. ADDRESS 8218 Wisconsin Ave.						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber										
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)	23b. DATE 07/24/87	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN Brentwood	23e. COUNTY Prince Geo.	23f. STATE MD	25a. DATE REC'D. BY REGISTRAR JUL 28 1987				25b. REGISTRAR'S SIGNATURE Julia Gardner-Landale
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be given to the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1 - STATE REGISTRAR			3 REG. NO. 21069									
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
Joan Doyle Stoddard						July 15, 1987			2:45p m			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Caucasian		October 16, 1917			69 yrs					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				Montgomery County, MD	
Washington, D.C.		United States										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital		Secretary			Hotel					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Rockville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7036 Sulky Lane / 20852			
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
C. Eugene				Doyle			Ruth				Cartwright	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
No		- 579-10-4839		Mr. John C. Stoddard, Husband, Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the lung</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of the lung</i> 2 years												
DUE TO, OR AS CONSEQUENCE OF (c) <i>Recurrent pulmonary embolism</i> 2 years												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from <i>April 26</i> , 1987, to <i>July 15</i> , 1987, that (I) (we) lost saw the deceased alive on <i>July 15</i> , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Eva Morrell</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>July 16, 1987</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Eva M. Morrell, M.D.</i>		22g. ADDRESS 6000 Executive Blvd. Rockville, Maryland 20852										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE July 18, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park			23d. LOCATION CITY OR TOWN Rockville COUNTY Maryland STATE					
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 1507 Wisconsin Ave. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR JUL 21 1987			25b. REGISTRAR'S SIGNATURE <i>Janice Parker-Kendall</i>					

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way) and will be diminished
as we approach the equator
and a return period will be

as we get to the
equator

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Name 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 7 REG. NO. 2 1 0 7 0											
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR
EDNA			MAE				STRAUSS		07/21/1987		2:20 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		WHITE		MONTH DAY YEAR SEPTEMBER 14, 1903		83		MONTHS DAYS		HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
WASHINGTON, DC		U. S. A.						MONTGOMERY COUNTY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13a. STREET ADDRESS / ZIP CODE		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL		LOBBYIST		1220 EAST WEST HIGHWAY 20910		BARNEY		DEBORAH	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO.	
MARYLAND		MONTGOMERY		SILVER SPRING				16c. IF YES, GIVE WAR OR DATES		217-32-1846	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:		4 days									
IMMEDIATE CAUSE (a)		Predominons Pneumonia									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Due to Myelocytic Leukemia									
(b)		1 year									
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from 15 Sept 86 to 21 Oct 87, that (I) (we) last saw the deceased alive on 15 Sept 86, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) examine the body after death.						COUNTY STATE					
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS				7/22/87					
Thomas A. Breisinger		7525 Grosvenor Ct. Drive Greenbelt MD									
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 7/23/1987		23c. NAME OF CEMETERY OR CREMATORIUM B'NAI ISRAEL CONGREGATION		23d. LOCATION OXON HILL CEMETERY		23e. PRINCIPAL COUNTY PRINCE GEORGE'S			
24a. FUNERAL DIRECTOR NAME								20770 MARYLAND			
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.											
24b. DATE REC'D. BY REGISTAR		24c. REC'D. BY DIRECTOR'S SIGNATURE		JUL 27 1987		D. Rendall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 REG. NO. 21071
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 6:30 AM	
Kathryn			E. STROH MIER			7-18-87				
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR 10 - 28 - 05			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE 1. STATE OR FOREIGN COUNTRY Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hosp.			12a. USUAL OCCUPATION Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 8502 16th St. / 20910										
14. FATHER'S NAME FIRST MIDDLE LAST Francis			15. MOTHER'S MAIDEN NAME Elizabeth			16. INFORMANT Ruth Hruska, same as #13			17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Esenias</i>			19. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Renal Disease</i>			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Weeks</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus - Hypertension - Tachycardia - Heart overload</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes mellitus - Hypertension - Tachycardia - Heart overload</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 77</i> to <i>July 18 1987</i> , that (I) (we) last saw the deceased alive on <i>July 17 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Hugo G Gravani</i>			22c. DEGREE 120			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>7-18-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hugo G Gravani 120</i>			22e. ADDRESS <i>717 Pershing Dr Silver Spring MD 20910</i>							
23a. BURIAL, CREMATION, REMOVAL 1. SPECIFY Burial			23b. DATE July 21, 1987			23c. NAME OF CEMETERY OR CREMATORIAL St. Monica's Cem.			23d. LOCATION CITY OR TOWN Chest Spring, Penna. COUNTY STATE	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814						25a. DATE REC'D. BY REGISTRAR <i>JUL 21 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Jane Pumphrey</i>	

0803-30 7/25/81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
Elizabeth Horne Strother						July	4, 1987					
3. SEX Female			4 RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR April 13, 1942			6 AGE (IN YEARS LAST BIRTHDAY) 45 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D. C.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6515 Broxburn Dr.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Economist			12b KIND OF BUSINESS OR INDUSTRY self-employed			
13a STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Bethesda			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 6515 Broxburn Dr. 20817		
14. FATHER'S NAME FIRST James			MIDDLE Quigley			LAST Horne			15. MOTHER'S MAIDEN NAME FIRST Marion			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. unavailable			17 INFORMANT David Strother (Spouse) same as (13)			ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Breast Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Mos.		
DUE TO, OR AS A CONSEQUENCE OF (b) (c)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1985, to July 3, 1987, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on July 3, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Bruce Kressel</i>										DEGREE		
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED July 4, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Kressel, M. D.			22e. ADDRESS 5480 Wisc. Ave., Chevy Chase, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE July 5, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Cremation			23d. LOCATION CITY OR TOWN Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME <i>James E. May</i>			24b. FIRM Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR 7-20-87			25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (Item 1a by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon/paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
87 REG. NO. 21073										
1 - DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR	
CORDELLE							STUBBS		07 23 87	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
F		W		04 10 94		93		7 PM YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		United States						Montgomery MD		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								
Silver Spring		Holy Cross Hospital								
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		
Maryland		Montgomery		Takoma Park				7525 Carroll Avenue, 20912		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		
Nathan Chappelle						Ida Sterling				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		16c		17 INFORMANT		ADDRESS		
No		206-14-8390				Nathalie Wells, 3939 South Dakota Ave. N.E.		Washington, D.C.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mycobacteric Kausasii</u> APPROXIMATE INTERVAL underlying cause lost. 2 years										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>dementia, malnutrition</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/85, 19, to 7/23/87, 19, that (I) (we) last saw the deceased alive on 7/23/87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Deborah B. Goldberg</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/23/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah B. Goldberg		22e. ADDRESS 1106 Spring St, Silver Spring, Md 20910								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/28/87		23c. NAME OF CEMETERY OR CREMATORIAL ROLLING GREEN MEM. PK		23d. LOCATION CITY OR TOWN West Chester, Pennsylvania				
24 FUNERAL DIRECTOR NAME McGuire Funeral Service, 7400 Georgia Ave. N.W.		ADDRESS Washington, DC		25a. DATE REC'D. BY REGISTRAR JUL 29 1987		25b. REGISTRAR'S SIGNATURE Julia Jackson-Randall				

06 JUL 2010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR		2 - FIRST NAME (TYPE OR PRINT)		LAST NAME (TYPE OR PRINT)		3a. DATE OF DEATH MONTH DAY YEAR		2b. REG. NO. 21074	
1b. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR JAN 26 41		6. AGE (IN YEARS LAST BIRTHDAY) 46		IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE Country Haiti		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. DATE OF DEATH MONTH DAY YEAR 07 04 87 18:15P	
10. CITY OR TOWN OF DEATH Takoma PK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7600 Carroll Ave, Takoma Park, MD		12a. USUAL OCCUPATION Chef		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md		13b. COUNTY Md		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 8603 Piney Branch Rd #101		ZIP CODE 20901	
14. FATHER'S NAME First Emilus		15. MOTHER'S MAIDEN NAME First Marielie		16. MIDDLE LAST Sully		17. INFORMANT Agnes M.C. Sully-Same as # 13 above		LAST Fontaine	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cryptococcus meningitis DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pneumonia. DUE TO, OR AS A CONSEQUENCE OF (c) Cryptococcus sepsis. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 3 1987 , to July 11 1987 , that (I) (we) last saw the deceased alive on July 4 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Apj - Wm</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 7/15/87			
22e. ADDRESS 5530 Wisconsin Ave, Chevy Chase									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE 7/11/87		23c. NAME OF CEMETERY OR CREMATORIAL HARMONY MEM. PARK		23d. LOCATION CITY OR TOWN Langover, P.G. Md.		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS		ADDRESS 4925 Burroughs Ave, W.F.		25a. DATE REC'D. BY REGISTRAR JUL 20 1987		25b. REGISTRAR'S SIGNATURE <i>John Tolson-Ludee</i>			

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- 15 -

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
DECEASED NAME (TYPE OR PRINT)				FIRST Viola	MIDDLE E.	LAST Swann	8 REG. NO. 21075	DATE OF DEATH 6-28-87	MONTH JULY	DAY 10	YEAR 1987	20 HOUR 2209P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3 - 9 - 00			6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Takoma		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson			12b. KIND OF BUSINESS OR INDUSTRY Dept. Store							
13a. STATE V		13b. COUNTY ---		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3634 Park Place, NW/20010 99999						
14. FATHER'S NAME FIRST William		MIDDLE D.	LAST Swann	15. MOTHER'S MAIDEN NAME FIRST Emma			MIDDLE V.	LAST Penny	ADDRESS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No ---		17. INFORMANT William Mason, 3638 Park Pl, NW, Wash., D.C.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		COPD, Pulmonary Arter Arterosclerotic Heart Disease												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c)		DUE TO, OR AS A CONSEQUENCE OF Arterosclerotic Heart Disease												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19, 86, to June 19, 87, that (I) (we) last saw the deceased alive on June 19, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Bonis Robbin and		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-29-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bonis Robbin and		22e. ADDRESS 1019 Univ. Blvd (Box S.S. and)												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/87		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary Star of Sea			23d. LOCATION CITY OR TOWN Indian Head, MD		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. DATE RECEIVED BY FUNERAL DIRECTOR JUL 10 1987			25b. REGISTRAR'S SIGNATURE Julia Barber Landau									

BP _____
99999
DHMH - 160M 7/84
(VRA 15, 4)

Items, 18a., & 22a., G-629, 7/2/87, by Med STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1076

1 - STATE EXAM., / Gbj.
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 201. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
STEPHEN CHANDLER TAME							<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9. DATE PRONOUNCED DEAD	6-16-87 19				M
MALE	White	8- 10-1951	36 yrs			6-16-87 19	6AM				M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Wash. D.C.		U.S.A.					Montgomery County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring		2900 Linden Lane			Surveyor		Surveying				
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MD.		Prince George's	Beetsville					11338 Cherry Hill Rd. #103			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.		17. INFORMANT				
Eckel Keith Tame		Mary I. Abbott			214-58-3277		Evel K. Tame				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Hypertrophic cardiomyopathy											
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Margarita A. Korell, M.D.			TITLE (SPECIFY) Assistant		M.D.		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6-19-87		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cem.			23d. LOCATION CITY OR TOWN Highland		COUNTY Howard		STATE Md.
24. FUNERAL DIRECTOR NAME Stack Funeral Home		ADDRESS Box 268 Ellicott City, Md. 21043		25a. DATE REC'D. BY REGISTRAR JUN 17 1987			25b. REGISTRAR'S SIGNATURE Julia Sander-Luders				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The

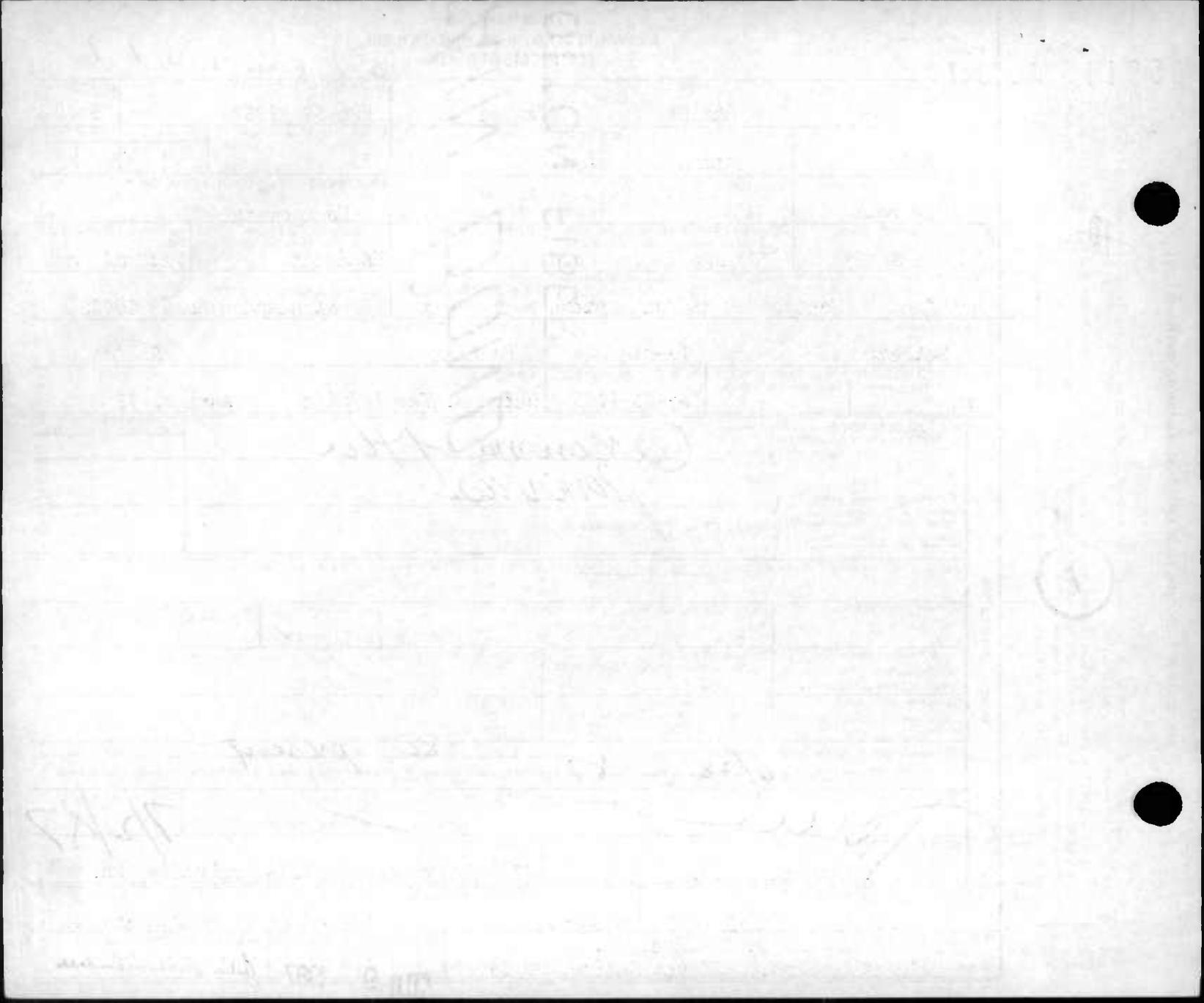
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tombstone permit. It is the privilege of the funeral director to remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21071

1. DECEASED NAME (TYPE OR PRINT) Henry Arthur Temple			2a. DATE OF DEATH MONTH DAY YEAR June 30, 1987			2b. HOUR 5:00 A.M.				
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 1 1904	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.					
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 700 Stonington Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Dept of Navy				
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 700 Stonington Road 20902					
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Temple			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 069-03-1105		17. INFORMANT Helen M. Temple/wife			ADDRESS same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>4/28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) write the body after death.									22b. DATE SIGNED <u>7/18/87</u>	
22c. SIGNATURE <u>John J. Merendino, M.D.</u>									22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. ADDRESS 4701 Randolph Road #216 Rockville, Md.									22f. DATE SIGNED <u>7/18/87</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 3, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn			23d. LOCATION CITY OR TOWN Rockville		23e. COUNTY Montgomery	23f. STATE MD
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W Silver Spring, MD 20901		25a. DATE REC'D. BY REGISTRAR -			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					



059294

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. IF PENDING, THE EXAMINER ALONG WITH FORM 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 4. PAGE 4 SHOULD BE USED AS A BURIAL TRAVEL PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2. REG. NO. 2078					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OR ESTI. DEATH MATED			2b. HOUR		
Delvin O. Thomas												July 3 1987 AM			2d. HOUR		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR	
F		Blk		Jan 24 1963			1		0		0		July 3 1987 AM			2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
New York			U.S.A.									Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
S. S. Hospital			Holy Cross Hosp			Presser			Laundry								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
MD			Montgomery			MD			NO			135 Univ. Blk 84, Apt 208					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST					
Isaac			Rambo						Mattie			White					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No			055-22-1285			Joseph Thomas (husband)			same			AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>																	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.												DUE TO, OR AS A CONSEQUENCE OF					
(b) <i></i>												DUE TO, OR AS A CONSEQUENCE OF					
(c) <i></i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>																	
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>J. L. Thomas</i>												TITLE (SPECIFY) MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 7-9-87			23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park Cem.			23d. LOCATION City or Town Rockville			COUNTY Montgomery		STATE Md.			
24. FUNERAL DIRECTOR NAME			ADDRESS George R. Snowden Rockville Md. 20850			25a. DATE REC'D. BY REGISTRAR JUL 9 1987			25b. REGISTRAR'S SIGNATURE Julia D. Wilson								

200-182

182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or remain with the deceased.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, be sure to mark Item 21.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81	REG. NO. 21079			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			26. HOUR					
Edna			M. Trail			July 23, 1987			9:55 a.m.					
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR Sept 7, 1933			6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS					
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Meat Wraper			12b. KIND OF BUSINESS OR INDUSTRY Retail Food					
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 10526 Westlake Drive/20817		
14. FATHER'S NAME FIRST MIDDLE LAST John Burton Duley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Whalen											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220 28 6419			17. INFORMANT Charles Allan Trail			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4386 Moleton Dr. Mt. Airy, MD 21771					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			MASSIVE PULMONARY EMBOLUS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION, HEAL BLOCK						7 days					
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 83			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 83 July 23, 1987									
22a. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1987</u> to <u>July 23, 1987</u> , that (I) (we) last saw the deceased alive on <u>July 23, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We will add and/or revise this body after death.)														
22b. SIGNATURE G. Peter Pushkas		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 7/23/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Peter Pushkas		22e. ADDRESS 11510 Old Georgetown Rd.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 27, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Rockville Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montgomery, Maryland						
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, Rockville, Inc 300 W. Montgomery Avenue Rockville, Maryland 20850						25a. DATE REC'D. BY REGISTRAR JUL 29 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Landale								

081540 JUL 30 1981

061847 AUG 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH21080
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Sam	Houston	Truitt	July 25, 1987				10:30 A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH	DAY	YEAR	58	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
ARKANSAS		U.S.A.						Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
SILVER SPRING		15 MANCHESTER PL. #302		SURVEYOR		CONSTRUCTION					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15 Manchester Place #302 20901			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		Sam	H.	TRUITT	ISABEL		-	-	BEERE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
YES		UNKNOWN		455-38-1164		Mrs. Iona M. Truitt, wife		same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cardiac Arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Months											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 21)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 14, 1982, to July 25, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										7/27/87	
22e. ADDRESS National Institutes of Health, 9000 Rockville Pike, Bethesda, Md. 20892											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE	
CREMATION		July 28, 1987		CHAMBERS CREMATORIAL		RIVERDALE		PG CO., MARYLAND			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Chambers Funeral Home		Silver Spring, Maryland		AUG 4 1987		Julia Davidson-Endalee					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at any time.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbamers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit pass. Please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 21082	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR ⁵⁰ 10 AM				
3. SEX M			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 7 20 17			6. AGE (IN YEARS LAST BIRTHDAY) 70			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			MD.	
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dental Tech.			12b. KIND OF BUSINESS OR INDUSTRY Group Health				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1524 Gridley Lane 20902				
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Urban			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Skowronski										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes (IF YES, GIVE WAR OR DATES) 1941-1945			16b. SOCIAL SECURITY NO. 126-05-1222			17. INFORMANT Winifred H. Urban/wife same as 13			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intestinal obstruction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several months</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic colon carcinoma</u>												DUE TO, OR AS A CONSEQUENCE OF <u>8 years</u>	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (in this hospital) attended the deceased from <u>July 28</u> , 1987, to <u>July 29</u> , 1987, that (we) last saw the deceased alive on <u>July 29</u> , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death. I have known him 10 months.													
22b. SIGNATURE <u>Barbara Blaylock</u>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 7-29-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Barbara Blaylock, M.D.</u>		22e. ADDRESS <u>6111 Executive Blvd., Rockville, md.</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 1, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION CITY OR TOWN Silver Spring COUNTY Montgomery STATE MD					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W Silver Spring, MD 20901					25a. DATE REC'D. BY REGISTRAR AUG 3 1987			25b. REGISTRAR'S SIGNATURE <u>Debra Landale</u>					

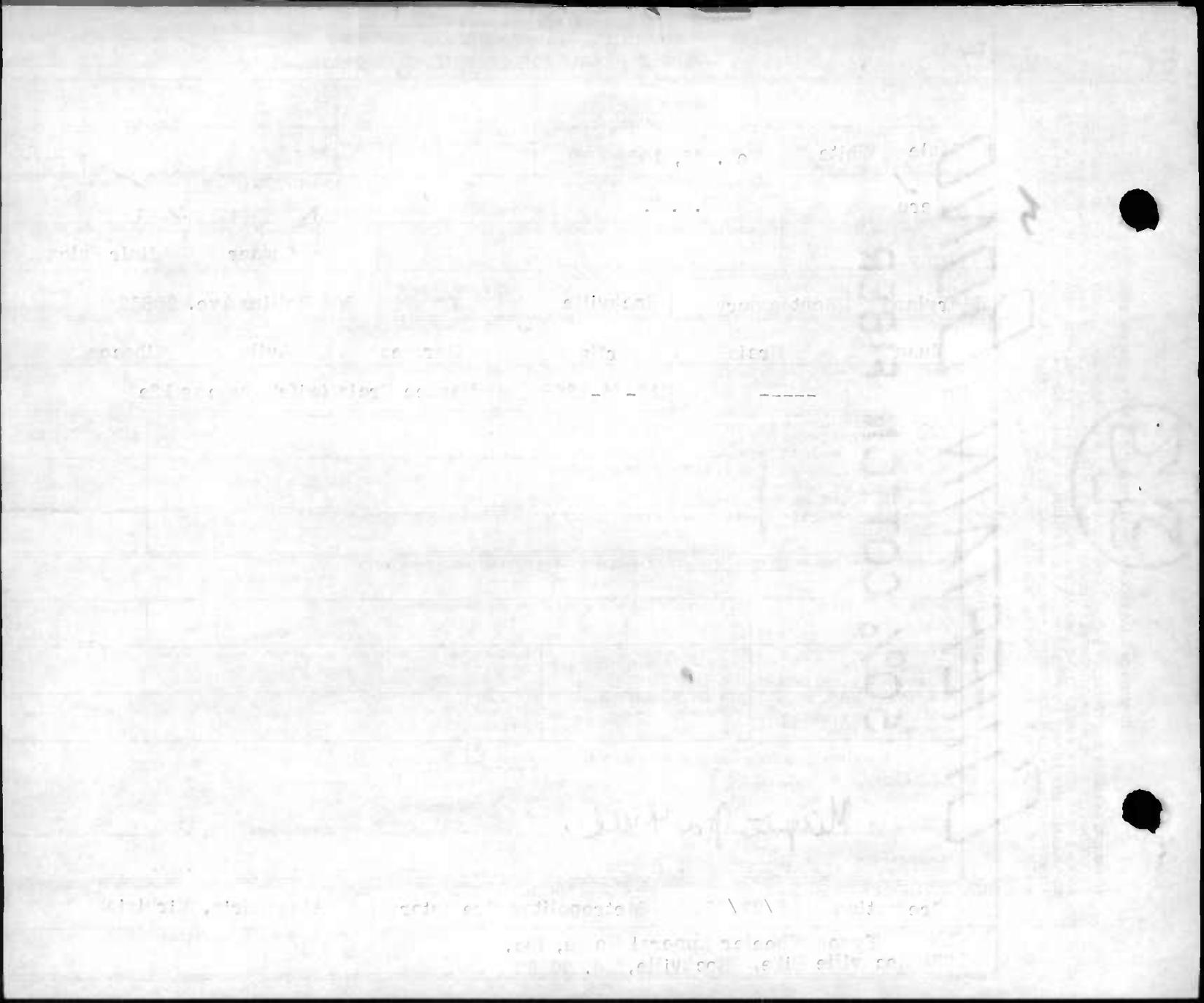
041654 VME-481

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items, 18a, Part #2, 21a.-22a., 6-23, by STATE OF MARYLAND
FOR Med. Ex., / Gbj., 7/2/87 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 1083
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
Jose			Bernabe	Urcia		<input checked="" type="checkbox"/>	6	22	1987	M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
Male	White	MONTH DAY YEAR Feb. 25, 1928	LAST BIRTHDAY 59 yrs.	MONTHS	DAYS	6	22	1987	P	M		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD		
Peru		U.S.A.					Montgomery County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Rockville		Rockville Cemetery					Owner			Hair Salon		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/>		206 Rollins Ave. 20852				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
		Juan	Urcia	Ortiz			Carmen	Avila	Chacon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		16d. ADDRESS						
No		219-64-2368		Haydee Urcia (wife)		same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self immolation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Cutting wounds of right arm; stabwounds to chest and neck												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:55 A.M. 6 22 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject set self on fire								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) cemetery		21f. LOCATION STREET off old Baltimore Road, Rockville, Maryland		CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St. Balto. MD.												DATE SIGNED 6/23/87
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/27/87		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria, Virginia		STATE				
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR JUN 29 1987		25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 21084	
1 - FOR STATE REGISTRAR		1 DECEASED NAME FIRST <u>Stamata</u> MIDDLE <u>---</u> LAST <u>Vergyri</u>				2a. DATE OF DEATH MONTH <u>7</u> DAY <u>3</u> YEAR <u>1987</u>				2b. HOUR <u>205 AM</u>			
59007 JUL 5 1987		3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>July</u> DAY <u>1</u> YEAR <u>1895</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>92</u>		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u> MIN. <u>0</u>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Greece</u>		7b. CITIZEN OF WHAT COUNTRY? <u>Greece</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.							
10. CITY OR TOWN OF DEATH <u>Bethesda Md</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Grosvenor Health Care Ctr</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>					
13a. STATE <u>MD</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>8016 Park Lane/20814</u>					
14. FATHER'S NAME FIRST <u>Petros</u> MIDDLE <u>---</u> LAST <u>Begetis</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Fotini</u> MIDDLE <u>---</u> LAST <u>Lagousakous</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>213-56-1877</u>		17. INFORMANT <u>P. Thomas Koinos, Same address as #13.</u>		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADVANCED PARALYSIS AGITANS</u>						6 YEARS					
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>						10 YRS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>INABILITY TO SWALLOW</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <u>---</u> MONTH <u>---</u> DAY <u>---</u> YEAR <u>---</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 24 1986</u> to <u>JULY 3 1987</u> , that (I) (we) last saw the deceased alive on <u>JUNE 28 1987</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>John B. Nasou, MD</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>7-3-87</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN B. NASOU, MD.</u>		22e. ADDRESS <u>800 BERSHING DR. SUITE 105A SILVER SPRING, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>7/7/87</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Silver Spring</u> COUNTY <u>MD</u> STATE <u>---</u>							
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisconsin Ave, NW, Washington, D.C. 20016</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 7 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>									
DHMH - 16 60M 7/84 (VRA 15, 4)													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 31085								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR									
Delia Walker						07 07 87			1200 N M									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
Female		B		01 04 21			66											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH								
Cuba		U.S.					Montgomery County MD.			Takoma PK								
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Washington Adventist Hospital 7600 - Carroll Ave, Takoma PK.		Custodian			Hospital		MD		P.G.		Adelphi		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20783 1800 - Metzerott Rd, Adelphi, Md.		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Emilio Monteago		Juona Ortega			NO		263-36-1616		Sandra Gray/1800 Metzerott Rd. Adelphi, Md.		Cardiac arrest							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					(b) Intractable congested ventricular arrhythmia													
					(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 End stage Renal failure Congestive heart failure, Diabetes, Aortic valve disease																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		7/3 1987			19 85		to 7/2 1987											
22b. SIGNATURE		A. A. Chacko			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS		7610 Carroll Ave. # 390 Takoma PK. MD 20912											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		7/11/87			Maryland National		Laurel											
24. FUNERAL DIRECTOR		McGuire Funeral Service 7400 Georgia Ave. Washington, D.C.			25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
					JUL 8 1987		Julia Gordon-Landale											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/transit or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other trauma, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21086			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			July 3, 1987	8:30 AM		
Maude Isabel Warfield															
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 03 DAY 22 YEAR 20			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			MD.			
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Domestic						
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Glenelg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 14419 Triadelphia Road 21737						
14. FATHER'S NAME FIRST Royal			MIDDLE Vernon			LAST Harp			15. MOTHER'S MAIDEN NAME FIRST Maude			MIDDLE Isabel		LAST Beasman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO			17. INFORMANT 216-70-2636			Kennard Warfield, Sr.			Glenelg, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Ventricular fibrillation			
DO TO, OR AS A CONSEQUENCE OF (b) Ventricular fibrillation. Heart disease															
DO TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Femoral artery occlusion															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Femoral artery occlusion			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/87</u> to <u>7/3/87</u> , that (I) <input type="checkbox"/> last saw the deceased alive on <u>7/1/87</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) (did not) view the body after death.												22c. DATE SIGNED 1987			
22b. SIGNATURE John G. Laramore, MD.			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 2901 Olney Sandy Lane Rd. Olney MD 20832						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Laramore, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 07-07-87			23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn Mem. Gard.			23d. LOCATION CITY OR TOWN Marriotsville Howard			COUNTY		STATE MD	
24. FUNERAL DIRECTOR NAME HAIGHT FUNERAL HOME SYKESVILLE, MD.									25a. DATE REC'D. BY REGISTRAR 1987			25b. REGISTRAR'S SIGNATURE Julie Sander Radler			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21081	
1 - STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
17-87			EDWARD A. WARREN						7 7 87			2035 M	
3		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
male		Black		7 11 35		51							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD							
Md.		USA											
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 708 Douglas Ave. 20850					
14. FATHER'S NAME Nathaniel Warren				15. MOTHER'S MAIDEN NAME Selah Edmunds									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-34-2900		17. INFORMANT ADDRESS Malinda Nokes (sister) Rockville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 d.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO, OR AS A CONSEQUENCE OF lung metastases 6 mo		(c) DUE TO, OR AS A CONSEQUENCE OF breast cancer 2 yrs									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (i) this hospital attended the deceased from saw the deceased alive on above (ii) (we) did (did not) view the body after death.		22b. SIGNATURE Peter Sherer		22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 7/8/87							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer		22f. ADDRESS 3947 Ferrara Dr. Wheaton, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-13-87		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park Cem.		23d. LOCATION CITY OR TOWN Rockville, Montg. MD							
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS Rockville, MD		25a. DATE REC'D. BY REGISTRAR JUL 14 1987		25b. REGISTRAR'S SIGNATURE George R. Snowden							

02883 77115

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH) WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

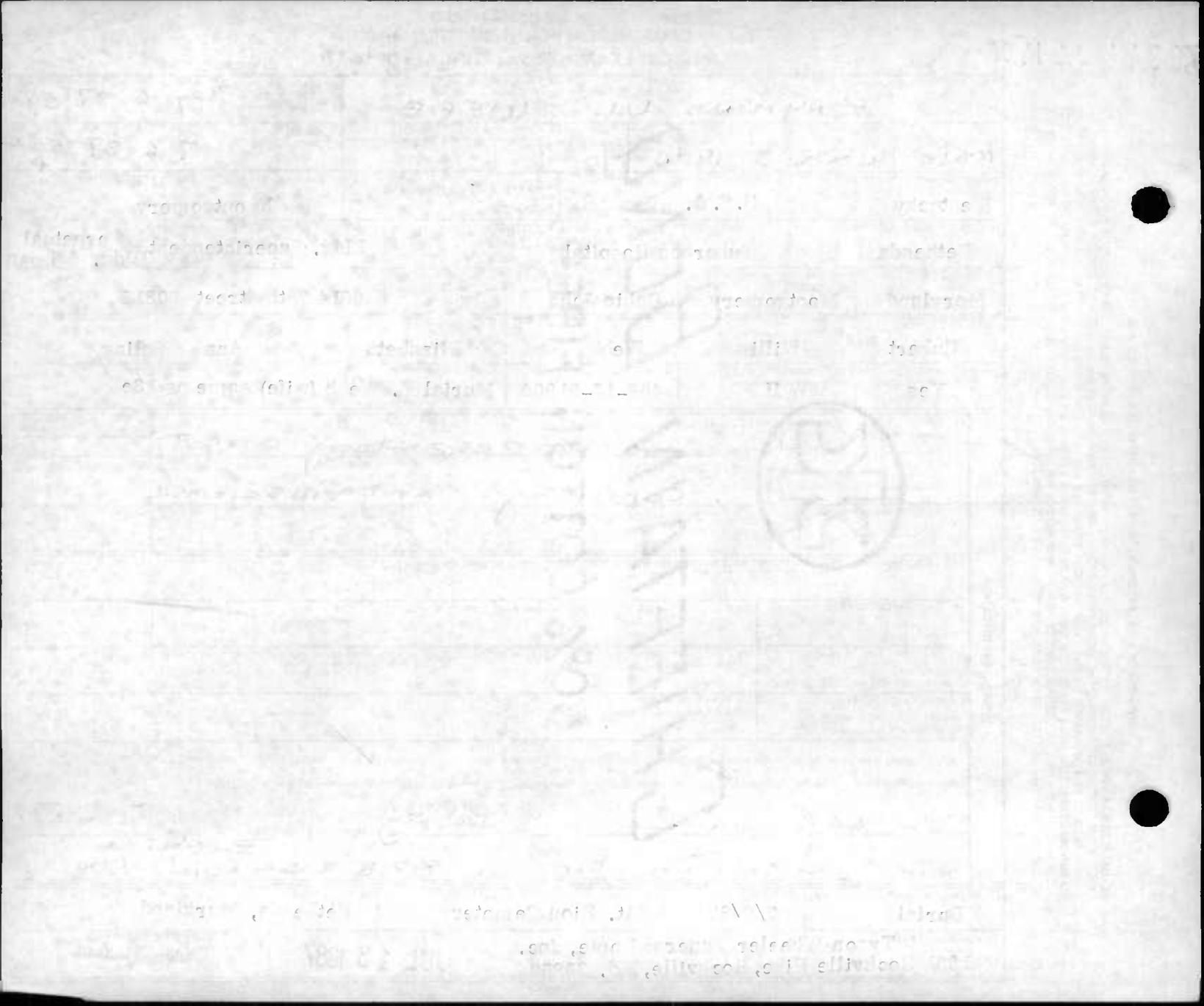
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												21088	REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED			2b. HOUR	
Nora			V.			Warren						7/27 1987			M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Female		Black		MAY 4 1947 40				MONTHS DAYS		HOURS MIN.		7/27 1987		8/7 1987 A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			MONTGOMERY							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly			Fr. Geo General Hospital			Disabled			20710							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Md. 4 Pr. Geo.			Bladensburg						6010 Logan Way #C1							
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST							
Nathaniel Brown						Luvenia Brunner										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			579-58-6832			Lisa Hampton			5130 Chester Ave Appt. 1B, Pa. 19143							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(b) DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?				
Operty												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE		Augusto P. Rodriguez, M.D.										TITLE (SPECIFY) M.D.		DATE SIGNED		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			5009 Rayburn Ct., Temple Hills, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			8-1-87			Lincoln Park Cem.			Rockville, Montg. MD							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
George R. Snowden			Rockville, MD20850			JUL 31 1987			John R. Landale							

186-98252

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, 3 AND 4. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 COULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1087	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH DAY YEAR	2b. HOUR 5:52 P.M.	
RAYMOND W. WEBB						7 6 87 19					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR	2d. HOUR 5:52 P.M.	
Male	White	5 12 15	72 yrs.			7 6 87 19					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Kentucky		U.S.A.						M ontgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK)			12b. KIND OF BUSINESS OR PERIODICAL Bldg. Superintendent Bldg. & Loan			
Bethesda		Suburban Hospital									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										MD	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6514 78th Street 20818			
14. FATHER'S NAME FIRST Hubert		MIDDLE Willis		LAST Webb		15. MOTHER'S MAIDEN NAME FIRST Elizabeth		MIDDLE Ann			LAST Saling
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF UNKNOWN, GIVE DATES)		16c. INFORMANT Muriel E. Webb (wife)		17. ADDRESS same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>cardio respiratory arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost.											
(b) <i>coronary</i> <i>arteriosclerosis</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			STATE		
									CITY OR TOWN	COUNTY	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>	
ACTUAL SIGNATURE <i>John Tamber</i>										TITLE (SPECIFY) M.D. Deputy, MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <i>John Tamber</i>										DATE SIGNED <i>7-6-87</i>	
ADDRESS <i>8208 WISCONSIN Ave.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 7/9/87			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Cemetery			23d. LOCATION CITY, TOWN, COUNTY Bethesda, Maryland		
Burial											
24. FUNERAL DIRECTOR NAME			Tyson Wheeler Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR JUL 13 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Landale</i>		
			1331 Rockville Pike, Rockville, Md. 20852								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										21090		
1. FOR 1. STATE REGISTRAR										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST Esther MIDDLE Morrell LAST Weber			2a DATE OF DEATH, MONTH DAY YEAR			2b HOUR			
Esther			Weber			7/14/87			0750 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		Caucasian		Feb. 16, 1900			87 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Pennsylvania		U.S.A.					Montgomery Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Rockville		Shady Grove Adventist Hosp.								Homemaker		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Montgomery		Gaithersburg						211 Russell Ave. 20877		
14. FATHER'S NAME		FIRST Ezra MIDDLE Morrell LAST		15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			17. INFORMANT		
				Annie			No 210-07-6886			daughter-in-law Adelhilde Weber, 8108 Hampden Ln. Bethesda, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) coronary artery disease												
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from 7-1-87 to 7-14-87, that (I) (we) last saw the deceased alive on 7-13-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 7-14-87
22b. SIGNATURE John Tauber		22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber			22e. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. ADDRESS 8218 WISCONSIN AVE Bethesda, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 16 July 87			23c. NAME OF CEMETERY OR CREMATORIAL Allegheny Cemetery			23d. LOCATION CITY OR TOWN Pittsburgh, Penna.			25a. DATE REC'D. BY REGISTRAR JUL 17 1987	
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA		ADDRESS									25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DHMH - 16 60M 7/84
(VRA 15, 4)

16 CS JUL 84 0020

(continued)

061668 AUG

587 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3721091
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST KEITH	MIDDLE HOWARD	LAST WEILER	20 DATE OF DEATH JULY 18, 1987	MONTH REG. NO.	DAY 3	YEAR 1091	2b HOUR 5:44 p.m.
3. SEX MALE			4 RACE WHITE	5. DATE OF BIRTH MONTH JULY DAY 20, 1919 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) CERAMIC ENGINEER TABLES CO.		12b KIND OF BUSINESS OR INDUSTRY MODERN		
13a STATE ALABAMA		13b COUNTY		13c CITY OR TOWN GADSDEN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1100 BELLEVUE DRIVE 35901		
14. FATHER'S NAME FIRST RAYMOND			MIDDLE JACKSON	LAST WEILER	15. MOTHER'S MAIDEN NAME FIRST GLADYS		MIDDLE	LAST WHITER		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII & KOREA		17. INFORMANT FRANCES H. WEILER, WIFE		ADDRESS (SAME)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			Multiorgan failure due to septic shock APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhagic diathesis, with multiple sites of bleeding							
			DUE TO, OR AS A CONSEQUENCE OF (c) History of Lymphoma							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 S/P Multiple chemotherapies										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 26, 19 1978, to JULY 18, 19 87, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JULY 18, 19 87, and that <input checked="" type="checkbox"/> (we) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) view the body after death.										
22b SIGNATURE Anthony F. Suffredini		22c DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN		22d DATE SIGNED 7/19/87				
22e PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY F. SUFFREDINI		22f ADDRESS NATIONAL INSTITUTES OF HEALTH 9000 ROCKVILLE PIKE, BETHESDA, MD. 20892								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 7/20/87		23c NAME OF CEMETERY OR CREMATORIAL COLLIER-BUTLER F.H.		23d LOCATION CITY OR TOWN GADSDEN, ALABAMA COUNTY STATE				
24 FUNERAL DIRECTOR MARSHALL'S FUNERAL HOME		ADDRESS 4217 9TH ST N.W. WASH, D.C.		25a DATE REC'D. BY REGISTRAR JUL 28 1987		25b REGISTRAR'S SIGNATURE Lisa S. S. Suffredini				

061669 VNC-281

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then placed above the signature, it should be delivered to me at the Bureau of Mortuary Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be called at once.

45, Per F.H. 7/21/87 16m

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3721092

060869 JUL 28 1987

RELEASED NAME Frank (TYPE OR PRINT) Frank			MIDDLE H.	LAST Weitzel	2a. DATE OF DEATH July 20, 1987	MONTH	DAY	YEAR	2b. HOUR 5:17 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Nov. DAY 9 YEAR 1907	6. AGE (IN YEARS LAST BIRTHDAY) 79			IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Comptroller					
12b. KIND OF BUSINESS OR INDUSTRY Gen.-US Govt.	13a. STREET ADDRESS / ZIP CODE 6294 - 29th St. NW 20015						13b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC 13b. COUNTY N/A 13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. MOTHER'S MAIDEN NAME Juliet					
13e. FATHER'S NAME FIRST Fred MIDDLE William LAST Weitzel	15. INFORMANT ADDRESS PA 16743			16. ADDRESS Wm. B. Weitzel 209 Grace Ave. Port Allegany, PA					
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PERFORATED DIVERTICULUM & PERITONITIS DUE TO, OR AS A CONSEQUENCE OF 2 weeks 2 weeks 2 weeks									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Myasthenia Gravis									
19a. DATE OF OPERATION 7/8/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated diverticulum			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 8, 1987 to July 20, 1987 , that (I) (we) last saw the deceased alive on July 19, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.									
22b. SIGNATURE Leanne D. Rubin	22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 7/20/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARRY D. RUBIN, MD	22e. ADDRESS 11120 New Hampshire Ave., Silver Spring, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/24/87	23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cem.			23d. LOCATION CITY OR TOWN Wash., DC		23e. COUNTY		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 WI Ave. NW Wash., DC 20016					25a. DATE REC'D. BY REGISTRAR 11/27/87 25b. REGISTRAR'S SIGNATURE				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed with the State Dept. of Health and Mental Hygiene prior to burial or removal, it should be retained for use by the burial-troupe personnel. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or death resulting from a traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87	REG. NO. 21093			
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
LILY MAY WEST	LILY	MAY	WEST	7	14	87		10 50 M
3. SEX Female	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3223 Farmington Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4890 Battery Lane #219				
14. FATHER'S NAME FIRST unknown	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST unknown	MIDDLE	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 579 48 9013	17. INFORMANT Mary Hill (friend)	ADDRESS 20815 2806 East West Hwy. Chevy Chase, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respirator Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastrointestinal Bleeding</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. acute leukemia								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>87</u> , to <u>7-14</u> , 19 <u>87</u> , that (I) <input type="checkbox"/> lost saw the deceased alive on <u>7-11</u> , 19 <u>87</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) (did not) view the body after death.								
22b. SIGNATURE <u>John Landers</u>	22c. DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <u>7-14-87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John Landers</u>	22e. ADDRESS <u>Bethesda Md.</u> <u>2184 1/2 COUSIN DR.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/17/87	23c. NAME OF CEMETERY OR CREMATORIAL ParklawnMemPark	23d. LOCATION CITY OR TOWN Rockville, Maryland	23e. COUNTY Rockville	23f. STATE Maryland			
24. FUNERAL DIRECTOR NAME <u>Lyson Wheeler</u> 1331 Rockville Pike Rockville, Md 20852	25a. DATE REC'D. BY REGISTRAR JUL 20 1987	25b. REGISTRAR'S SIGNATURE <u>John Landers</u>						
BP								
DHMH - 16 60M 7/84 (VRA 15, 4)								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before this certificate is filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 21094				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Eudell Garfield									Whitten			7-24-87				1910 P
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH 12 DAY 12 YEAR 09			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS 72 YRS		IF UNDER 24 HRS MONTHS 12 HOURS 00 MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.							
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Shady Grove Adventist			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY U.S. Government							
13a. STATE Md			13b. COUNTY Mont.			13c. CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 410 Girard St. * 304 20878				
14. FATHER'S NAME FIRST Eudell			MIDDLE Garfield			LAST Whitten			15. MOTHER'S MAIDEN NAME Vera			Elise Spear				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No			16c. ADDRESS			17. INFORMANT Betty J. Whitten			Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) DUE TO, OR AS A CONSEQUENCE OF Respiratory insufficiency (c) DUE TO, OR AS A CONSEQUENCE OF cardiac arrest												6 wks 6 wks				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Dementia, Stroke																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 7/24 1987 to 7/24 1987, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.												22c. DATE SIGNED 7/25/87				
22b. SIGNATURE Peter Sherer			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer, M.D.			22e. ADDRESS 3947 Ferrara Drive Wheaton, MD. 20906													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 27, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Norbeck Memorial Park			23d. LOCATION Olney			CITY OR TOWN		COUNTY		STATE
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/Rockville, Inc.			300 W. Montgomery Ave., Rockville, MD. 20850			25a. DATE REC'D. BY REGISTRAR JUL 29 1987			25b. REGISTRAR'S SIGNATURE Lisa E. Johnson							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

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relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please attach this certificate to the burial papers. Pages 1 and 2 should be filled in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if any of items 18 through 20 are checked, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO. 31095															
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Jewell Janese WIKLE					WIKLE	7/14/87			7	14	87	7:30 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			white			MONTH 8 DAY 15 YEAR 09			77			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
West Virginia			United States						Montgomery County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Takoma Park			Washington Adventist Hospital			Housewife			Own home						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Montgomery		Silver Spring					9312 Piney Branch Road / 20903					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
Quincey					Stover	Margaret					Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
No			233-50-0411			Walter W. WIKLE, Same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												CARDIAC ARREST			
DUE TO, OR AS A CONSEQUENCE OF (b)												MYOCARDIAL INFARCTION			
DUE TO, OR AS A CONSEQUENCE OF (c)												CORONARY ARTERY DISEASE			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19-86 to 19-87, that (I) (we) last saw the deceased alive on 19-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED			
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN		July 14, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			11. ADDRESS												
HECTOR K. COLLISON M.D.			1111 SPRING ST SS MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Burial			7-18-87			Sunset Memorial Park			Beckley, West Virginia						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Melton Mortuary 1200 Harper Road, Beckley, WV 25801															
JUL 17 1987												John Davidson-Randall			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this form removes carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is checked or Item 18 shows any injury or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 21090

1. RELEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ROBERT CHARLES			-	WILBUR		7 29 87				2:36 PM	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH 6 DAY 28 YEAR 38			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
M		WHITE				49		YRS.			
7a. BIRTHPLACE (CITY, STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTG. CO. MD.				
Olean, N.Y.		USA									
10. CITY OR TOWN OF DEATH OLNEY MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL-Pre Health			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST WORKING LIFE) Security Guard		12b. KIND OF BUSINESS OR INDUSTRY				
Md.		13a. STATE Md.	13b. COUNTY None.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2601 Bel Pre Rd 20901				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME UNAVAILABLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) YES 8-4-56 2-3-57 113-30-2682			17. INFORMANT MR. L. KILLIE		ADDRESS VA ADMINISTRATION HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		sudden cardio pulmonary arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/29/87				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		{ (b) Quadriplegia Progressive Demyelitic Disease Due to, or as a consequence of years									
19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET —		CITY OR TOWN —		COUNTY — STATE —		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7/13/87 19 —, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE 			22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 7/29/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. OSOTH LEKAGUL		22e. ADDRESS 7425 Arlington Rd Bethesda MD									
23a. BURIAL, CREMATION, REMOVAL (RECEIPT)		23b. DATE 8-8-87		23c. NAME OF CEMETERY OR CREMATORIAL CHESTERHAM CEM.		23d. LOCATION CITY OR TOWN CHESTERHAM, MD		COUNTY P.C.		STATE	
24. FUNERAL DIRECTOR NAME W.H. BACON		ADDRESS 3244 7th St.		25a. DATE RECEIVED BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE John D. Danner					

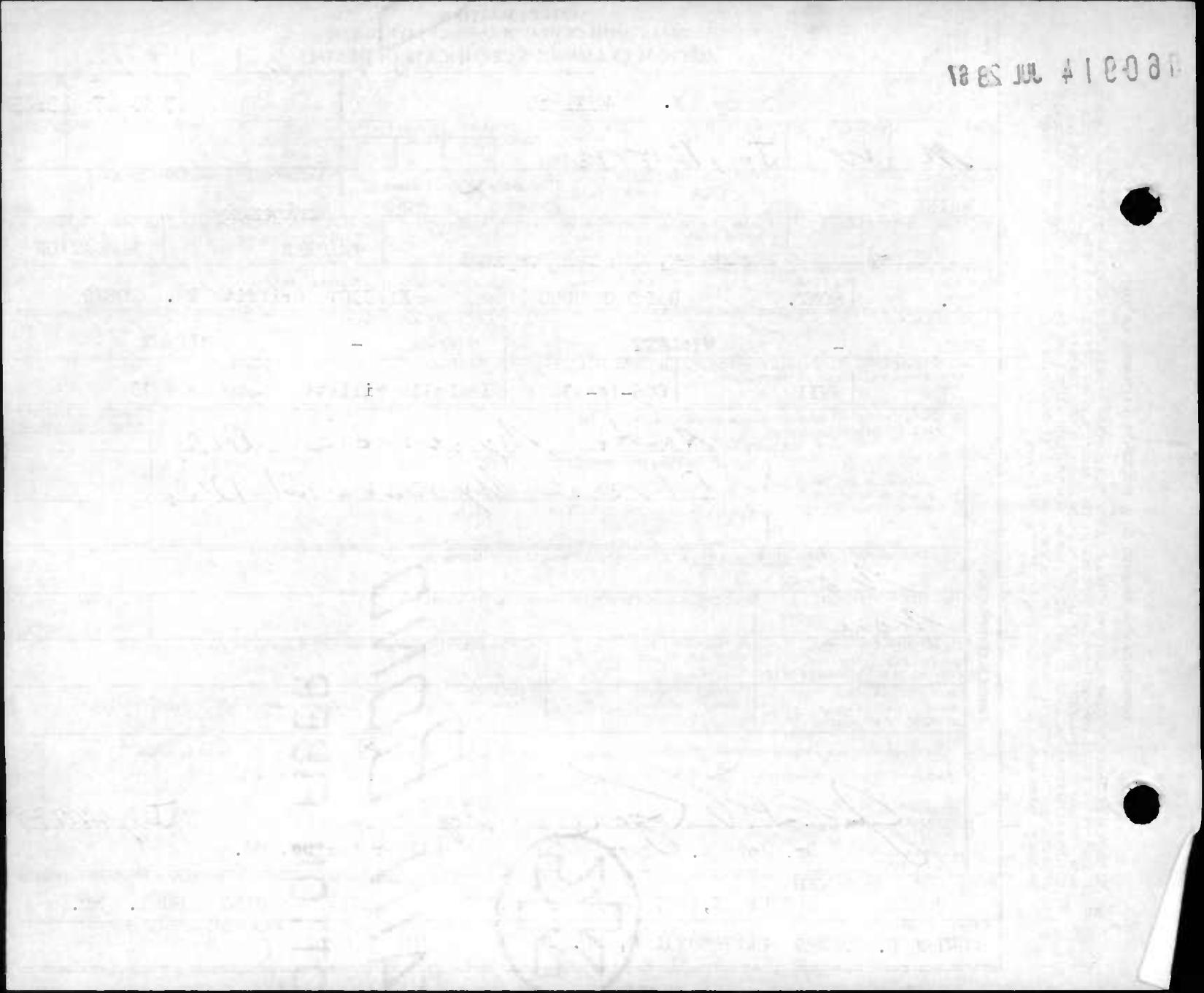
10 11 2011 00:59:00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN APPEAL IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGES 1, 2, AND 3 FOR 24 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 9 1				
1- STATE REGISTRAR				LAST				2a. DATE KNOWN OF DEATH				MONTH DAY YEAR				
(TYPE OR PRINT)				Percy W. Willett				07 23 87				12:45A				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2b. HOUR		
<i>M</i>		<i>W</i>		July 12, 1973			73 yrs.			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR		
MAINE		USA		MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			19 M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION		
Olney		Montgomery General Hospital										TEACHER		EDUCATION		
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN GAIITHERSBURG			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		5501 Griffith Rd. 20879					
14. FATHER'S NAME FRED				WILLETT			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. MOTHER'S MAIDEN NAME		ADDRESS							
YES		WWII		006-14-9309A			EMMA		Isabella Willett		Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>																
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John S. Rogers</i>														Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		
TITLE (SPECIFY) M.D. <i>Dr. John S. Rogers</i>														MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 25, 1987		23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN			23d. LOCATION CITY OR TOWN SILVER SPRING		COUNTY MONT.		STATE MD.					
24. FUNERAL DIRECTOR MURIEL H. BARBER		LAYTONSVILLE, MD. 20879														
25a. DATE REC'D. BY REGISTRAR JUL 27 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Deardon-Randall</i>														
BP		DHHM - 17 (VR A15 ME (5)) 20M 4/82														

1285 111 410030



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is incomplete or Item 18 is not signed, any injury or other traumatic event, the medical examiner shall be notified and an inquest will be held.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 8 / REG. NO. 21098											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
George Lawrence Williams						7 23 87			23-31 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Caucasian		May 9, 1912			75			YRS.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Washington, D.C.		U.S.A.					Montgomery County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park		Washington Adventist Hospital		Chef			Restaurant				
13a. STATE Maryland		13b. COUNTY P.G.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. STREET ADDRESS / ZIP CODE 5645 Sargent Road 20782				
14. FATHER'S NAME FIRST Joseph		MIDDLE Williams		15. MOTHER'S MAIDEN NAME Ida			16. ADDRESS 809 Gerry Lane				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 577-12-0131		17. INFORMANT Lorraine Barnett (Daughter)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
							ACUTE RESPIRATORY FAILURE				
							DUE TO OR AS A CONSEQUENCE OF (b) ACUTE EXACERBATION of Emphysema And Congestive heart failure				
							DUE TO OR AS A CONSEQUENCE OF (c) Bleeding stress ulcer in stomach				
19. MEDICAL CERTIFICATION		20a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/18/87 to 7/23/87, that (I) (we) lost saw the deceased alive on 7/23/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.		22b. SIGNATURE S. R. UDAPI, MD. NUR		22c. DATE SIGNED 7/24/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHRINIVAS R. UDAPI		22e. ADDRESS 6005 LANDOVER RD. CHEVERLY, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 07/25/87		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria			COUNTY STATE Virginia	
Francis Gasch's Sons Funeral Home P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR JUL 28 1987						25b. REGISTRAR'S SIGNATURE H. W. WILSON	

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CLEARED BY DR. MAYLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 2 should be detached for use as the burial/transit permit. Then page 2 should be sent within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 8 shows any injury, attach a separate sheet of paper and describe the injury in detail.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				RENO. 21099	
1. FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
060398 JUL 23 1987	Elizabeth	Cass	Wills	July 20, 1987	3:00 a.m.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 2, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9706 Bellevue Drive	12a. USUAL OCCUPATION (IF WORKING) Asst. Professor	12b. KIND OF BUSINESS OR INDUSTRY Russel Sage College		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9706 Bellevue Drive / 20814	
14. FATHER'S NAME FIRST James	MIDDLE Michael	LAST Cass	15. MOTHER'S MAIDEN NAME FIRST Julia	MIDDLE	LAST Monnett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No -	16c. INFORMANT Mr. J. Henry Wills, Husband, Same as #13	ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction				24 hours	
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease				5 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 31 October 1977, to 20 July 1987, that (I) (we) last saw the deceased alive on 1 June 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Eugene P. Libre, M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED July 20, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Libre, M.D.	22e. ADDRESS 10400 Connecticut Avenue Kensington, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE July 21, 1987	23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory	23d. LOCATION CITY OR TOWN Alexandria	COUNTY	STATE Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814	25a. DATE REC'D. BY REGISTRAR 7-28-87	25b. REGISTRAR'S SIGNATURE			
DHMH - 16 60M 7/84 (VRA 15, 4)					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH21100
REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Aynes Irene Wilson						07/16/87				11:15 AM	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
Female	Caucasian	January 27, 1914			73 yrs.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Iowa	United States				Montgomery Co. MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Rockville	Shady Grove Adventist Hosp.					Homemaker					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland	Montgomery	Gaithersburg				18622 Walkers Choice Rd. #31 20879					
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S M AIDEN NAME FIRST			MIDDLE	LAST				
John		Zaver	Helen				Heitz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband)			ADDRESS					
NO	579 14 9424		Robert D. Wilson			Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POSSIBLE CEREBROVASCULAR ACCIDENT</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>RENAL FAILURE</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>HEPATIC INSUFFICIENCY</u>											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1 1987</u> to <u>JULY 16 1987</u> , that (I) (we) last saw the deceased alive on <u>JULY 16 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE <u>William Stern MD</u>	22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 7-16-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS			14816 PHYSICIANS LANE, Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN CEM.			23d. LOCATION CITY OR TOWN	23e. COUNTY		23f. STATE			
Burial	July 21, 1987				Silver Spring			Maryland			
24. FUNERAL DIRECTOR Rockville, Inc.	ADDRESS 300 West Montgomery Ave. Rockville, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
				JUL 21 1987			JULIA DAWSON-LINDALE				

000331 197228

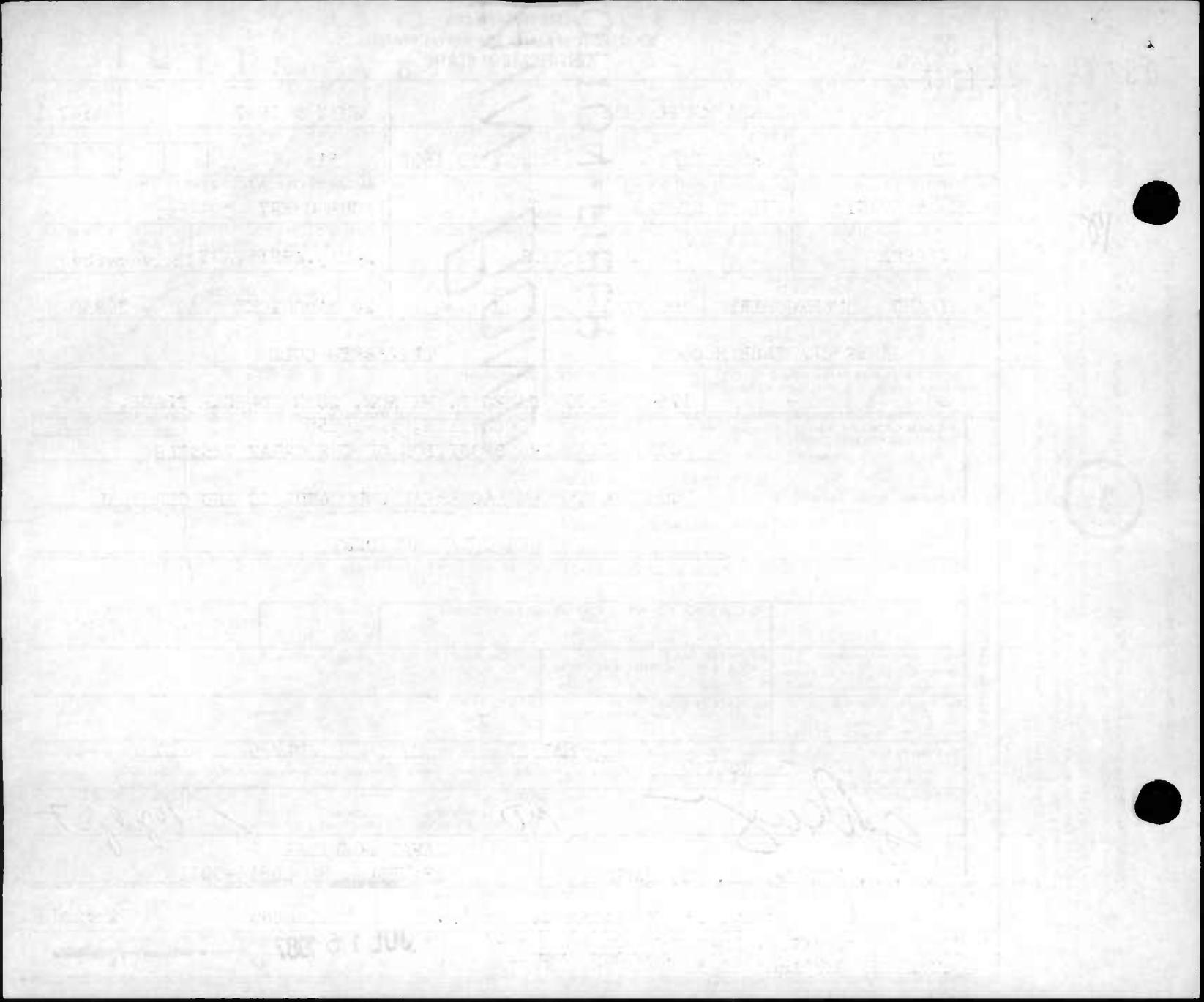
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Funeral Director, page 3 should be detached for use on the burial-trust permit. Then please attach the death papers, pages 1 and 2, should be left with the funeral director, or with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 67110					
1. FOR STATE REGISTRAR	2. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
	BARBARA MARIE WILSON					JULY 9 1987				4:47 P	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH FEBRUARY 23 1936			6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN		
7a. BIRTHPLACE COUNTRY PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.						
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. ASSISTANT					12b. KIND OF BUSINESS OR INDUSTRY University		
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 20 HARDWICKE PLACE 20850					
14. FATHER'S NAME FIRST JAMES CLARENCE MCCOOG	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST ELIZABETH COLE			MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. -	17. INFORMANT JAMES P. WILSON, 20 HARDWICKE PLACE,			ADDRESS ROCKVILLE, MD 20850						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL TRANSPOSITION OF THE GREAT VESSELS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DO TO, OR AS A CONSEQUENCE OF (b) COMPLICATED BY BACTERIAL ENDOCARDITIS AND CEREBRAL											
DO TO, OR AS A CONSEQUENCE OF (c) VASCULAR ACCIDENT											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from MAY 27, 1987, to JULY 9, 1987, that (I) (we) last saw the deceased alive on JULY 9, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John D. Dowgin</i>			DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED July 6, 1987				
22d. PHYSICAL AND NAME (TYPE OR PRINT) A. DOWGIN, LT, MC, USNR			22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 13, 1987	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National			23d. LOCATION CITY OR TOWN Arlington	COUNTY	STATE Virginia				
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850			25a. DATE RECEIVED BY REGISTRAR JULY 15 1987			25b. REGISTRAR'S SIGNATURE <i>John D. Dowgin</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-2. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES HAND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2102					
1- FOR STATE REGISTRAR 8-10-87 SB per FH				Item 15, Film G630													
2- DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE KNOWN OF ESTI- DEATH MATED			2b MONTH MONTH		2c DAY DAY		2d YEAR YEAR	
Frank			L.		Windsor, Sr.		July 26, 1987			11:00 A.M.		11:00 A.M.		11:00 A.M.		11:00 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2e DATE PRONOUNCED DEAD		2f DATE CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH	
M		W		June 14, 1967		70						July 26, 1987		USA		Montgomery MD	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14. KIND OF BUSINESS OR INDUSTRY									
Washington, D.C.		S. Y. 1987		Elmwood Cross Hospital		Installer		C & P									
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. STATE		17. COUNTY		18. CITY OR TOWN		19. STREET ADDRESS									
M. S. 1987		Md.		Montgomery		S. Y. 1987		12905 Goodhill Road		20906							
20. FATHER'S NAME		21. MOTHER'S MAIDEN NAME		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
Edwin		Windsor															
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		24. SOCIAL SECURITY NO.		25. INFORMANT		26. ADDRESS											
Yes		WW II		212-14-5706		Lillian C. Windsor		Wife		Same as 13							
27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.																	
(b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
29. DATE OF OPERATION None		30. CONDITION FOR WHICH OPERATION WAS PERFORMED?		31. AUTOPSY?													
32. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)													
35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		37. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
38. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
39. ACTUAL SIGNATURE <i>John S. Rogers</i>		40. TITLE (SPECIFY) M.D. <i>Op.</i>		41. MEDICAL EXAMINER		42. DATE SIGNED <i>July 26, 1987</i>											
43. EXAMINER'S NAME (TYPE OR PRINT)		44. ADDRESS <i>1919 Seminary Road Silver Spring, Md.</i>															
45. BURIAL, CREMATION, REMOVAL (SPECIFY)		46. DATE <i>July 29, 1987</i>		47. NAME OF CEMETERY OR CREMATORIAL <i>George Washington</i>		48. LOCATION CITY OR TOWN <i>Adelphi Pr. Geo. Maryland</i>											
49. BURIAL		50. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>		51. DATE REC'D. BY REGISTRAR <i>JUL 29 1987</i>		52. REGISTRAR'S SIGNATURE <i>Julia Davidson-Ladouce</i>											
(VR A15 ME (5))																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial/transit permit. Then please remove and sign pages 1 and 2 which should be mailed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual condition, the medical examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8 6 2 1 1 0 3 REG. NO.													
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			
	Dorothy Brannon						Woolard			7/13/87			
2. DATE OF DEATH	MONTH		DAY		YEAR		2b HOUR						
JUL 21 87	7/13/87		13		16		10:45 P						
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Female	cauc			1 3 16			71						
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
WVA	USA						MONTGOMERY CO. MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Silver Spring	Holy CROSS Hospital			Registered Nurse			Union						
13a. STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Maryland	Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>			11552 February Circle 20904					
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME												
FIRST	LAST			FIRST	LAST								
Fred	Brannon			Hallie	Hite								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No	465-30-9408			Daughter			1716 Kilbourne Pl., NW Washington, D.C. 20010						
Robin L. Horvath													
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiop. recovery</i> 5/4													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis of aorta</i> 2/2													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN						
22a. I certify that (I) (this hospital) attended the deceased from 8/13/87, 19 80, to 7/13, 19 87, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Edgar H. Levin, M.D.</i>				DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edgar H. Levin, M.D.</i>										22e. DATE SIGNED <i>7/14/87</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE July 15, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory Alexandria			23d. LOCATION CITY OR TOWN Alexandria						
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.										25a. DATE REC'D. BY REGISTRAR JUL 20 1987	25b. REGISTRAR'S SIGNATURE		
500 University Blvd., W. Silver Spring, Md. 20901													

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the physician and completely filled in by the funeral director, page 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST		
Louise			L.			Wyatt					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White			MONTH DAY YEAR Dec. 19, 1909			77		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
NC			U.S.A.						Montgomery		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hospital			Broker			Real Estate		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS / ZIP CODE		
DC			N/A			Wash.			5000 Hurst Terr. NW 20999		
14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME								
FIRST John			MIDDLE Ferris			LAST Ledford			FIRST Bessie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			118-28-4739			Bess L. Ormand			Concord, NC 28025		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAN D10 - Pulmonary Arrest</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. <u>Sudden</u> (b) <u>Congestive Heart Failure</u> (c) <u>Cerebral Vascular Disease</u> YEARS DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7/26/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									COUNTY		
22b. SIGNATURE <u>Joseph A Vassallo</u>						DEGREE			STATE		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED <u>7/28/87</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
Cremation			7/28/87			Mt. Comfort Crematory			Alexandria, VA		
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
						AUG 3 1987			Julie Deidra Landers		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use in the burial permit. Then please remove this paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 contains any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												21105											
CEASED NAME											REG. NO.												
FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR										
Margaret Jean						Yasher			July 12, 1987				A 9:50 M										
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS											
Female	Caucasian		MONTH DAY YEAR			54			MONTHS	YEARS	MONTHS	YEARS	HOURS	MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Pennsylvania	USA		October 5, 1932			Montgomery			Silver Spring	15107 Interlachen Drive #318	Nursing Admin.	General Hosp.	Montgomery	MD.									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Maryland	Montgomery	Silver Spring	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			15107 Interlachen Drive #318			Thomas	F.	Wallace	Stella	Wass	16b. SOCIAL SECURITY NO.	171-26-1002	Michael R. Yasher Husband Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY																							
IMMEDIATE CAUSE (a)												Respiratory Failure											
DUE TO, OR AS A CONSEQUENCE OF																							
(b) Metastatic breast cancer																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.c																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
			HOUR A.M. MONTH DAY YEAR			P.M. 19			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			CITY OR TOWN			COUNTY			STATE								
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from												22b. DATE SIGNED											
saw the deceased alive on												July 12, 1987											
above, (I) (we) did (did not) view the body after death.												John G. Lomell, MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS											
John G. Lomell, MD.												8901 Olney Sandy Spring Rd. 20832											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION			CITY OR TOWN			COUNTY								
Burial			July 16, 1987			Gate of Heaven			Silver Spring			Montgomery			Md.								
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR											
NAME Francis J. Collins, Jr.												25b. REGISTRAR'S SIGNATURE											
ADDRESS												500 University Blvd. W. Silver Spring, Md. 20901											
JUL 20 1987												JUL 20 1987											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1a. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER IN PENCIL. PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGE 4 SHOULD BE FORWARDED TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1- STATE REGISTRAR		2 REG. NO. 106											
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH	DAY	YEAR	2b. HOUR
Heung		Joong		Yoon				<input checked="" type="checkbox"/>		7/13	19	87	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN			2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR
Male	Oriental	Mar. 5, 1911	76 yrs.					<input checked="" type="checkbox"/>		7/13	19	87	8:40 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Korea		Korea						Montgomery County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		8902 Manchester Road, #307		Shoemaker		self-employed							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		20901			
Maryland		Montgomery		Silver Spring				8902 Manchester Road, #307					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Irpyung				Yoon		Shinja				Choi			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no		220-98-9718		Aki Yoon/wife		same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Bronchial pneumonia. DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													
{ (b) DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
None													
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY)									
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, M.D.		M.D.		Deputy		MEDICAL EXAMINER		DATE SIGNED		7/13/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE			
Burial		July 15, 1987		Gate of Heaven		Silver Spring		Montgomery		MD			
24. FUNERAL DIRECTOR NAME		Francis J. Collins, Jr.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
500 University Blvd., W		Silver Spring, MD 20901				JUL 20 1987		Julia Dawson-Randall					

1815 M 831080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 21101				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Salvatore Paul Zannelli												July 16, 1987				11:26am
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		Caucasian		Month Day Year December 21, 1906			80 YRS.			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED X			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Washington, D.C.		United States		NEVER MARRIED DIVORCED			Montgomery County,									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda		Suburban Hospital			Projectionist			Movie Theater								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Montgomery		Garrett Park						11114 Kenilworth Ave. /20896						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME														
FIRST Augustus		MIDDLE Zannelli			LAST Pauline											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT (Daughter)			ADDRESS			11346 Palisades Ct.					
Yes		W.W. II 578 03 2428			Sally P. Keen			Kensington, Md. 20895								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one hour</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary heart Disease</i> (c) <i>Hypertension</i>												Several years Several years.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>chronic Pulmonary lung disease</i>																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7/16/87</u> to <u>7/16/87</u> , that (I) (we) last saw the deceased alive on <u>7/16/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED July 16, 1987				
22b. SIGNATURE <i>Samuel Z., M.D.</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Faruk T. Ozer, M.D.		22e. ADDRESS						22f. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 20, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood		COUNTY		STATE Maryland				
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland								25a. DATE REC'D. BY REGISTRAR JUL 21 1987		25b. REGISTRAR'S SIGNATURE <i>Landale</i>						

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed "within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, then

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) Fay Brennan Zirkin			2a. DATE OF DEATH MONTH DAY YEAR July 6, 1987	2b. HOUR 8 A.M.
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR June 6, 1900	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE COUNTRY Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House	12a. USUAL OCCUPATION Homemaker	12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE 4701 Willard Ave. 20815
14. FATHER'S NAME FIRST Edmund	MIDDLE Brennan	15. MOTHER'S MAIDEN NAME FIRST Manola	MIDDLE Ready	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-20-2203	17. INFORMANT Dianne Z.Welling	ADDRESS Potomac, Md. 10223 Gainsborough	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years 20 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Parkinson's Disease				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>July 20</u> , 19 <u>87</u> , to <u>July 6</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>July 5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.				
22b. SIGNATURE John D. Herman, M.D.	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Herman M.D.	22e. ADDRESS 4425 Montgomery Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 10, 1987	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Mausoleum	23d. LOCATION CITY OR TOWN Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME The Hysong Co. 1300 N St. N.W. Wash. D.C.	ADDRESS	25a. DATE REC'D. BY REGISTRAR 1987 7 11 28	25b. REGISTRAR'S SIGNATURE	

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061142 JUL 29 1987 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 21109
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORUMA M. 3. RETAIN PAGES 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9a. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	Cauc	10 29 10	76 yrs.			07 25 1987	100			AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Michigan			USA			NEVER MARRIED DIVORCED			Montgomery		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK)			12b. KIND OF BUSINESS Chief of the Adm. Law of Judges		
Bethesda			Suburban Hospital			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 9912 E. Boxhill Dr		
13a. STATE MD			13b. COUNTY Montgomery			13c. CITY OR TOWN Kensington			14. FATHER'S NAME Osias		
15. MOTHER'S MAIDEN NAME Hannah			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT ADDRESS Wife: Alice G. Zwerdling same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (c)											
PART 2 DATER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0904 P.M. 7 25 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) Collapsed at home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET 9912 E Boxhill Dr CITY OR TOWN Kensington COUNTY Montgomery STATE MD					
22a. I certify that I took charge of the remains described above, held an death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
EXAMINER'S NAME (TYPE OR PRINT)			EXAMINER'S NAME (TYPE OR PRINT)			TITLE (SPECIFY) M.D. DEPT			MEDICAL EXAMINER		
Francis C. Mayle			Francis C. Mayle			ADDRESS 320 Wisconsin Ave Bethesda MD			DATE SIGNED 7/25/87 208 14 100		
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE July 27, 1987			23c. NAME OF CEMETERY OR CREMATORIAL King David Mem. Pk.			23d. LOCATION CITY OR TOWN Falls Church, Va. COUNTY STATE		
24. FUNERAL DIRECTOR NAME			Eves-Pearson Funeral Homes Falls Church, Va. 22046			25a. DATE REC'D. BY REGISTRAR JUL 28 1987			25b. REGISTRAR'S SIGNATURE John Pearson		

1605 JUL 24 1980